



## MEDCARE CLINICS @ WALMART MARKHAM

500 Copper Creek Drive (inside Walmart) • Markham, Ontario • L6B 0S1, Canada

Phone: (905) 205 1400 • Fax: (905) 205 0088

Email: markham@medcareclinics.com • Web: www.medcareclinics.com

### Request to Release Patient Health Information to MedCare Clinics

#### PATIENT INFORMATION

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_ Apt. #: \_\_\_\_\_  
City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
Telephone #: \_\_\_\_\_ Health Card #: \_\_\_\_\_

#### PERMISSION TO SHARE: I give my permission to share my protected health information:

##### FROM:

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Telephone #: \_\_\_\_\_  
Fax #: \_\_\_\_\_

##### TO:

MedCare Clinics @ Walmart Markham  
500 Copper Creek Drive (inside Walmart)  
Markham, Ontario – L6B 0S1, Canada  
Tel #: 905-205-1400 Fax #: 905-205-0088  
Email: markham@medcareclinics.com

##### Send By:

☐ Mail ☐ Fax ☐ Patient Pick-up ☐ E-Mail

#### INFORMATION REQUESTED TO BE RELEASED

- |  |  |
|--|--|
| <input type="checkbox"/> All Medical Record                  | <input type="checkbox"/> Pathology Reports             |
| <input type="checkbox"/> Operative Reports                   | <input type="checkbox"/> X-Ray/Lab/MRI/CT Scan Reports |
| <input type="checkbox"/> Other (please specify below): _____ |  |

#### DISCLAIMER

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. I consent to MedCare Clinics @ Walmart Markham, including its staff and providers, to obtain my health information. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. MedCare Clinics @ Walmart Markham keeps all personal and health information strictly confidential and secure. No medical or health information will be provided over the phone. MedCare Clinics @ Walmart Markham will not disclose any personal or health information to any third party (without prior consent). I acknowledge that I will be responsible for any associated fees to obtaining my medical records. I acknowledge that I have read and fully understand this form, disclaimers and policies, including data breach of personal information. By signing this document, I understand that I agree to waive any and all claims that I have or may have in the future against the MedCare Clinics @ Walmart Markham its directors, affiliates, owners/operators, employees, physicians (collectively the "releasees"). I agree to release the Releasees from any and all liability for any loss, damage or injury that my next of kin or I may suffer as a result of the improper release of medical information, malpractice, including negligence, breach of contract, privacy breach, data breach or breach of any statutory or other duty of care.

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Signature of parent/guardian: \_\_\_\_\_