



## MEDCARE CLINICS @ MULOCK DRIVE MEDICAL CENTRE

140 Mulock Drive, Unit 8 & 9 • Newmarket, Ontario • L3Y 7C5, Canada

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### Release Request of Patient Health Information from 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:

MedCare Clinics @ Mulock Drive Medical Centre  
140 Mulock Drive – Unit 8 & 9  
Newmarket, Ontario, L3Y 7C5, Canada  
Tel #: 905-830-4242 Fax #: 905-898-2220  
Email: [newmarket@medcareclinics.com](mailto:newmarket@medcareclinics.com)

**All records will be sent via fax**

TO:

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone #: \_\_\_\_\_

Fax #: \_\_\_\_\_

#### INFORMATION REQUESTED TO BE RELEASED

All Medical Record

Operative Reports

Other (please specify below): \_\_\_\_\_  
\_\_\_\_\_

Pathology Reports

X-Ray/Lab/MRI/CT Scan Reports

#### 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 @ Mulock Drive Medical Centre, including its staff and providers, to release my health information and medical records to the above mentioned. 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 @ Mulock Drive Medical Centre keeps all personal and health information strictly confidential and secure. No medical or health information will be provided over the phone or via email. MedCare Clinics @ Mulock Drive Medical Centre 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 releasing my medical records. Records will only be release once payment is made in full. 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 @ Mulock Drive Medical Centre, 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: \_\_\_\_\_

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