MEDCARE CLINICS @ NIAGARA SQUARE

7555 Montrose Road, Unit # E2 • Niagara Falls, Ontario • L2H 2E9, Canada
Phone: (289) 292 0441 • Fax: (289) 292 0451
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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:	TO:
Name: _____ Address:_____ _____ Telephone #: _____ Fax #: _____	MedCare Clinics @ Niagara Square 7555 Montrose Road – Unit # E2 Niagara Falls, Ontario, L2H 2E9, Canada Tel #: 289-292-0441 Fax #: 289-292-0451 Email: niagara@medcareclinics.com Send By: ☐ Mail ☐ Fax ☐ Patient Pick-up ☐ E-Mail

INFORMATION REQUESTED TO BE RELEASED

☐ All Medical Record
☐ Operative Reports
☐ Pathology Reports
☐ X-Ray/Lab/MRI/CT Scan Reports
☐ 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 @ Niagara Square, 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 @ Niagara Square 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 @ Niagara Square 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 @ Niagara Square, 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: _____