



MEDCARE CLINICS @ PORTAGE ROAD MEDICAL CENTRE

3643 Portage Road, Unit # 15 • Niagara Falls, Ontario • L2J 2K8, Canada

Phone: (905) 354 2422 • Fax: (905) 354 6004

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

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 @ Portage Road Medical Centre
3643 Portage Road – Unit # 15
Niagara Falls, Ontario, L2J 2K8, Canada
Tel #: 905-354-2422 Fax #: 905-354-6004

All records will be sent via fax

TO:

Name: _____
Address: _____

Telephone #: _____
Fax #: _____

INFORMATION REQUESTED TO BE RELEASED

- | | |
|--|--|
| ☐ All Medical Record | ☐ Pathology Reports |
| ☐ Operative 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 @ Portage Road 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 @ Portage Road 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 @ Portage Road 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 @ Portage Road 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: _____

Date: _____ Signature of parent/guardian: _____

OFFICE USE ONLY

Payment amount: _____ Payment method: _____ Scanned to EMR: [] Records sent by: _____