MEDCARE CLINICS @ RIVERVIEW HEIGHTS

20 Rivermont Road, Unit B8 & B9 • Brampton, Ontario • L6Y 6G7, 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:	TO:
MedCare Clinics @ Riverview Heights 20 Rivermont Road, Unit B8 & B9 Brampton, Ontario, L6Y 6G7, Canada Tel #: 905-454-1222 Fax #: 905-455-0123 Email: riverview@medcareclinics.com **All records will be sent via fax**	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 @ Riverview Heights, 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 @ Riverview Heights 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 @ Riverview Heights 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 @ Riverview Heights, 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: _____