



MEDCARE CLINICS @ SCOTT STREET

387 Scott Street, Unit A2C • St. Catharines, Ontario • L2M 3W2 - Canada

Phone: (905) 646 8383 • Fax: (905) 646 0202

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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:
Scott Street Medical Centre (MedCare Clinics) 387 Scott Street – Unit A2C St. Catharines, Ontario – L2M 3W2 Tel #: 905-646-8383 Fax #: 905-646-0202	Name: _____
Send By: <input type="checkbox"/> Regular Mail <input type="checkbox"/> Fax <input type="checkbox"/> Patient Pick-up <input type="checkbox"/> Courier	Address: _____ _____
	Telephone #: _____
	Fax #: _____

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	
<p>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 @ Scott Street (Scott Street 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 @ Scott Street (Scott Street 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 @ Scott Street (Scott Street 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 @ Scott Street (Scott Street 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.</p>	
Date: _____	Signature: _____
Date: _____	Signature of parent/guardian: _____

OFFICE USE ONLY

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