MEDCARE CLINICS @ SOUTH PELHAM ROAD (WELLAND)
589 South Pelham Road, Unit 125 • Welland, Ontario • L3C 3C7, Canada
Phone: (905) 788 3000 • Fax: (905) 984 8881
Email: welland@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:	TO:
MedCare Clinics @ South Pelham Road (Welland) 589 South Pelham Road, Unit 125 Welland, Ontario, L3C 3C7, Canada Tel #: 905-788-3000 Fax #: 905-984-8881 Email: welland@medcareclinics.com Send By: Regular Mail Fax Patient Pick-up Courier	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): ____
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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 @ South Pelham Road (Welland), 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 @ South Pelham Road (Welland) 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 @ South Pelham Road (Welland) 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 @ South Pelham Road (Welland), 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: ____________________________

OFFICE USE ONLY
Payment amount: _______ Payment method: _________ Scanned to EMR: [ ] Records sent by: __________