



MEDCARE CLINICS @ WALMART VAUGHAN NORTHWEST

3600 Major MacKenzie Drive West, Unit # 3 • Vaughan, Ontario • L4H 3T6, 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 @ Walmart Vaughan Northwest 3600 Major MacKenzie Drive West – Unit # 3 Vaughan, Ontario – L4H 3T6, Canada Tel #: 905-303-4003 Fax #: 905-303-4305	Name: _____ Address: _____ _____
Send By: <input type="checkbox"/> Regular Mail <input type="checkbox"/> Fax <input type="checkbox"/> Patient Pick-up <input type="checkbox"/> Courier	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 @ Walmart Vaughan Northwest, 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 @ Walmart Vaughan Northwest 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 @ Walmart Vaughan Northwest 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 @ Walmart Vaughan Northwest, 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: _____