West Carleton

Family Health Team

Form: D5

AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORDS TO WCFHT

1. Regarding Patient ***COMPLETE IN FULL (See reverse side for instructions.)***

Name - Last, First, MI		
Street Address		**Telephone # (xxx) xxx-xxxx**
City	**Province**	**Postal Code**
Date of Birth mm/dd/yyyy		

2. Records Released From

Name - (e.g. Health Facility, Physician,..)		
Street Address		**Unit #**
City	**Province**	**Postal Code**
Phone # (xxx) xxx-xxxx	**Fax # (xxx) xxx-xxxx**	

3. Records Released To

Name - (e.g. Insurance Co., Lawyer, Physician, Self,...) **West Carleton Family Health Team**		
Street Address **119 Langstaff Dr., Box 218**		**Unit #**
City **Carp**	**Province** **Ontario**	**Postal Code** **K0A 1L0**
Phone # (xxx) xxx-xxxx **(613) 839-3271**	**Fax # (xxx) xxx-xxxx** **(613) 839-3273**	

4. INFORMATION TO BE RELEASED: (Check all applicable categories)

- ☐ **Complete Copy of All Records**
- ☐ Lab Reports
- ☐ Allergy Records
- ☐ Telephone/verbal communication
- ☐ Itemization/Coding
- ☐ X-ray Reports/films
- ☐ Counseling & Consultation Visits
- ☐ Immunization Records
- ☐ Clinic records pertaining to outpatient treatment of: (Specify approximate date(s) or condition) _____
- ☐ Other (Specify) _____

FOR THE FOLLOWING DATES: _____

5. PURPOSE OR NEED FOR DISCLOSURE: (Check applicable categories)

- ☐ Further Medical Care
- ☐ Payment of Insurance Claim
- ☐ Application for Insurance
- ☐ Legal Investigation
- ☐ Personal
- ☐ School Disability
- ☐ Academics
- ☐ Transfer of Health Care
- ☐ Other: _____

6. This authorization will remain in effect until this request is processed unless you specify this authorization will be effective for an additional time period. Written consent is necessary to revoke this request.

- ☐ Additional time period. Specify: _____
- ☐ **NONE**
- ☐ Include future records generated during the additional time period

7. I authorize release of my medical records in accordance with the specification listed above. I understand that I have a right to inspect and receive a copy of the disclosed material. A photocopy of this consent shall be valid as the original. I understand that any costs for this service shall be my responsibility.

8. Signature of patient _____ **Date** _____

WEST CARLETON family health centre
keeping our community healthy

• Dr. Barry Bruce • Dr. Ewa Ciechanska • Dr. Jeanette Dionne • Dr. Karen Ferguson
• Dr. Mark Fraser • Dr. Michelle Lawler • Dr. Kathy McBride • Dr. Lisa Rosenkrantz
• Dr. R Stecher • Dr. Kristen Tonon • Dr. Eugene Vigneron
119 Langstaff Drive, P.O. Box 218, Carp, ON K0A 1L0
Tel: 613.839.3271 • **Fax**: 613.839.3273 • www.wcfht.ca

(If signed by person other than patient, state relationship and authority to do so.)

ADDITIONAL INFORMATION REGARDING DISCLOSURE OF PATIENT MEDICAL INFORMATION

Revocation. You have the right to revoke this authorization, in writing, at any time before it ends. However, your written revocation will not affect any disclosures of your medical information that the person(s) and/or organization(s) listed on the reverse side of this form have already made, in reliance on this authorization, before the time you revoke it. In addition, if this authorization was obtained for the purpose of insurance coverage, your revocation may not be effective in certain circumstances where the insurer is contesting a claim. Your revocation must be made in writing and addressed to:

West Carleton Family Health Team, 119 Langstaff Dr., Carp, ON, K0A 1L0

Right to Inspect. You have the right to inspect or copy the medical information whose disclosure you are authorizing.

Copying Fees. There may be a copy fee charge for disclosure and release of medical information as authorized by your signature. The copy charges must be paid before the documentation is released.

Signatures. Generally, if you are 16 years of age or older, you are the only person who is permitted to sign a form to authorize the disclosure of your medical information. If you are under the age of 16, your parent or guardian must sign this form for you. A spouse can not authorize disclosure of medical information for you unless they have legal rights to do so.

This form must form part of your medical record, and any associated charges paid, before the documentation is released.

PLEASE FAX OR MAIL THE COMPLETED FORM TO THE PROVIDER SHOWN IN SECTION 2.