West Carleton
Family Health Team

Form: D6

AUTHORIZATION FOR DISCLOSURE MEDICAL RECORDS FROM 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,..) 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	

3. Records Released To

Name - (e.g. Insurance Co., Lawyer, Physician, Self,…)		
Street Address		**Unit #**
City	**Province**	Postal Code
Phone # (xxx) xxx-xxxx	**Fax # (xxx) xxx-xxxx**	

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

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