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 323 mary		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**
- ☐ Telephone/verbal communication
- ☐ Counseling & Consultation Visits
- ☐ Lab Reports
- ☐ Itemization/Coding
- ☐ Immunization Records
- ☐ Allergy Records
- ☐ X-ray Reports/films
- ☐ 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
- ☐ Legal Investigation
- ☐ Academics
- ☐ Payment of Insurance Claim
- ☐ Personal
- ☐ Transfer of Health Care
- ☐ Application for Insurance
- ☐ School Disability
- ☐ 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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