ODS

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Medical Record Request Form

Name ____________________ Phone # ____________

Address ____________________ Postal Code ____________

City ____________________ Province ____________

Email ____________________

I do hereby authorize ODS to transfer a copy of all medical records belonging to Dr.__________________, Please put Doctor's Name here,

Pertaining to :

Name ____________________ D.O.B. ____________

Name ____________________ D.O.B. ____________

Name ____________________ D.O.B. ____________

Name ____________________ D.O.B. ____________

Name ____________________ D.O.B. ____________

I understand and am willing to pay a fee to cover the cost to duplicate and **deliver my medical information to :(if different from above)**

Charges are in accordance with the Ontario Medical Association(OMA) recommended charges, ODS's charges are less than the rates set by the OMA

Name ____________________ Phone ____________

Address ____________________ Postal Code ____________

City ____________________ Province ____________

I release ODS and Dr. __________________________ from all and any legal liability from the duplication and/or transfer of the above medical records. I am aware that all medical records that will be copied may contain medical information relating to different aspects of my/our medical history, including but not limited to mental health, drug records and/or HIV test results.

This shall be my good and sufficient authority to provide and transfer a copy of my(may include minors under 18 years) medical records.

Signature ____________________

Signature ____________________

Signature ____________________

Signature ____________________

Signature ____________________

ODS will only use personal information to maintain this agreement and otherwise as required by law. Facsimiles of this agreement will be treated as originals if agreed upon by ODS.