Meadowlands Family Health Center

Barry Dworkin, MDCM, CCFP*
Stuart Kurtz, MDCM, CCFP*
Sen-Mei Lim, MD, CCFP
Sara Gunnink, MD, CCFP
Joanne Tannenbaum, MDCM, CCFP
Paul Fluit, MD, CCFP*
Jillian Bardsley, MD, CCFP

Anthony Lofaro, B.Sc., MD. CCFP
Minjeong Eom, MD, CCFP*
Christiana Yao, MD, CCFP
Sjaan Gerth, B.SC., MD, CCFP*
Alisha Campbell, MD, CCFP
Maia Lawson, MD, CCFP
Shamim Taherzadeh, MD, CCFP*

STOP **Please note that each section of the form must be completed in its entirety.** ***Failure to specify (including dates) will delay the processing of your request.***

Patient Information

Patient Name: ____
Last / First / Middle / Maiden (If applicable)

Gender ☐ Male ☐ Female

Date of Birth: __________________________ (year/month/day)

Phone: (   ) _________________________

Release To

Name: ______________________________

Organization : **Meadowlands Family Health Center**

Street Address: **16-888 Meadowlands Drive East Ottawa ON K2C 3R2**

Telephone: **613-228-2882**

Fax: 613-228-2856

Purpose

Records are to be released for the following purposes: (Select all that apply)

☐ Medical Care ☐ Attorney/Legal ☐ Personal ☐ Insurance ☐ Disability ☐ Other:____________________

Information to Be Released

Information Requested From:____

Dates of Treatment/Particular Illness/Admission Requested: ____

☐ Discharge Summary ☐ Emergency Department Record ☐ Radiology Lab Reports
☐ History & Physical ☐ Immunizations ☐ Consultation Reports, ☐ Specify MD/Specialty: _______________
☐ Operative Reports ☐ Requisition (Blood work/Radiology) ☐ **Whole Chart**

Patient/Parent/Legal Guardian Authorization

Unless otherwise revoked, this Authorization will not expire. This Authorization may be revoked at any time. However, the revocation will not apply to uses or disclosures occurring prior to our receipt of your revocation request. In order to revoke the Authorization the individual/parent/legal guardian must submit a revocation request in writing to the address below.

I, the undersigned, hereby authorize Meadowlands Family Health Center to use and/or disclose information from my medical record as specified above.

Signature of Patient: ____________________________________Date:______________________
(if 16 years of age or older OR is Legal Guardian/POA)

Submit

Please verify that all sections are completed in full. If not in the clinic, please send the form to:

Meadowlands Family Health Center
888 Meadowlands Drive East
Ottawa, ON
K2C 3R2

OR

Fax the form to: 613-228-2856

*******PLEASE DO NOT FAX A CHART TRANSFER OR DOCUMENT MORE THAN 15 PAGES, PLEASE MAIL*******