Records Management

Patient Request for Copy and / or Transfer of MEDICAL RECORDS

Records Management Ltd. has been authorized by Dr. C. Zides to receive and store, as his/her designee, and on his/her behalf, his/her patients' medical records, and to provide and / or transfer copies when requested by the patient. Please be advised that the cost of obtaining and / or transferring copies of your Medical Record is not covered by provincial health insurance, and you will therefore be responsible for the cost of the duplication and / or transfer of your Medical Records, if requested. Please note that as the authorized storage facility for Dr. C. Zides , **your Medical Records will be kept by Records Management for at least 10 years after your last professional visit to Dr. C. Zides or, in case of a minor, for at least 10 years following the minor's eighteenth birthday.**

The charge for duplicating and / or transferring your Medical Record is in accordance with your Provincial Medical Association or as otherwise directed by or as required by applicable law.

Please, complete Sections A-E. **We will not process an incomplete form.**

Part A – I would like to receive my Medical Records on (if you do not make a selection you will receive your records printed on paper):

☐ Email Delivery ☐ CD / Soft Copy

☐ Paper

For additional copy, please select: ☐ CD / Soft Copy ☐ Paper

$10 will apply for each additional copy

Email Address: _____

Part B – Method of payment (Form to be returned by mail or fax):

☐ Cheque / Money Order payable to Records Management Ltd. ☐ Pay Online

☐ E-Transfer / Please send E-Transfers to info@recordsregistry.ca with the password as records:

☐ Credit Card information included with this consent form.

Credit Card Type: ☐ Visa ☐ Master Card ☐ Amex

Credit Card Number: | | | | | | | | | | | | | | | | |

Expiry Date: | | / | | |

Cardholders Name: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Signature of cardholder: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Date: (dd/mm/yyyy) | | | | | | | | |

Part C – Authorization (Must be completed and signed by each adult over the age of 16):

Patient 1

Patient Last Name:

First Name: | Middle Initial: | Date of Birth: (dd/mm/yyyy) | Sex

Street No. and Name or Lot: | Apt. No.

City, Town or Village | Prov. | Postal Code

Patient 2

Patient Last Name:

First Name: | Middle Initial: | Date of Birth: (dd/mm/yyyy) | Sex

Street No. and Name or Lot: | Apt. No.

City, Town or Village | Prov. | Postal Code

PRINT GUARDIAN NAME:

I am the legal guardian for the following minor (under the age of 16) patient(s) of Dr. **C. Zides**

Patient 3

Patient Last Name:

First Name: | Middle Initial: | Date of Birth: (dd/mm/yyyy) | Sex

Street No. and Name or Lot: | Apt. No.

City, Town or Village | Prov. | Postal Code

Patient 4

Patient Last Name:

First Name: | Middle Initial: | Date of Birth: (dd/mm/yyyy) | Sex

Street No. and Name or Lot: | Apt. No.

City, Town or Village | Prov. | Postal Code

Patient 5

Patient Last Name:

First Name: | Middle Initial: | Date of Birth: (dd/mm/yyyy) | Sex

Street No. and Name or Lot: | Apt. No.

City, Town or Village | Prov. | Postal Code

Part D – Declaration

I hereby direct and authorize Dr. C. Zides and RECORDS MANAGEMENT LTD. to provide and / or transfer a copy of my Medical Records (or those of a minor of whom I am a legal guardian) as follows:

☐ Deliver to my address above

☐ Deliver to Doctor named below:

Doctor's Last Name: First Name:

Street No. and Name or Lot: Suite No.

City, Town or Village Prov. Postal Code

Phone No. Fax No.

I understand that a copy fee charge for disclosure and release of medical information of

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will apply as authorized by my signature. The copy charges must be paid before the documentation is released.

Part E – Signature of Patient

I hereby release Records Management Ltd. and Dr. C. Zides from any and all legal liability that may arise as a result of the duplication and / or transfer of these Medical records. I understand that any and all information in these Medical Records shall be copies and released, including but not limited to, mental health records, drug and / or alcohol abuse records and / or HIV test results, if any. This shall be Records Management's and Dr. C. Zides full and sufficient authority for providing and transferring a copy of my Medical Records as indicated:

Patient 1 Signature: Date: (dd/mm/yyyy)

Patient 2 Signature: Date: (dd/mm/yyyy)

Legal Guardian Signature: Date: (dd/mm/yyyy)

Confidentiality Obligations: Except as otherwise provided in this Agreement, the Medical Records shall remain the exclusive property of Dr. C. Zides and will only be used by Records Management Ltd. for the permitted purposes provided herein or as otherwise compelled by law. The obligations to ensure and protect the confidentiality of the confidential information imposed on Records Management Ltd. in this Agreement and any obligations to provide notice under this Agreement will survive the expiration or termination, as the case may be, of this Agreement. Records Management Ltd agrees to provide access to the original individual's medical file at no cost only when patient's identity is confirmed and sufficient notice is given. Files are strictly reviewed by patients on site (office area). Records Management Ltd. agrees to retain all confidential information at the usual place of business and to store all confidential information separate from other information and documents held in the same location. Further, the confidential information is not to be used, reproduced, transformed, or stored on a computer device that is accessible to person to whom disclosure may not be made, as set out in this Agreement.

Miscellaneous Personal Information: The patient consents to Records Management Ltd.'s collection, use and disclosure of all personal information disclosed to Records Management Ltd. in this form, in the application process or in the ongoing administration of this Agreement. Records Management Ltd. will only collect or disclose the patient's personal information to identify and contact the patient or to perform any other necessary functions relating to the administration of this Agreement or otherwise as required by law. A facsimile copy of this Agreement with facsimile signatures will be treated as an original and will be admissible as evidence of this Agreement. This Agreement shall be construed according to the laws of Province of Ontario. Records Management Ltd. is entitled to conduct a personal investigation or credit check upon the patient, subject to applicable legislation. The parties agree that this document be written in English. This Agreement shall not become binding upon Records Management Ltd. until accepted by Records Management Ltd. This Agreement is binding on the patient's heirs, executors, administrators, successors and permitted assignees. If more than one patient is named under this Agreement, the liability of each patient shall be joint and several. Clerical errors shall not affect the validity of this Agreement and Records Management Ltd. shall be entitled to correct all clerical errors provided that the patient is given notice of the correction. This Agreement constitutes the entire Agreement between the patient and Records Management Ltd. Records Management Ltd. has reated and implemented a privacy policy in compliance with PIPEDA and PHIPA to ensure that no personal information is collected, used or disclosed without the consent of the patient involved and / or Dr. C. Zides or as otherwise required by law.

OFFICE USE ONLY: **QC2:** **Business Date:**