Date: ________________________

RAINY RIVER CANNABIS COLLECTIVE

Authorization to Release Medical Records

Name of Patient: ____

Date of Birth: ___________________ Medical Card Number: _____________________

Is requesting that __________________________________ release health information to Rainy River Cannabis Collective.

Rainy River Cannabis Collective
35 Blake Hall Rd
Thunder Bay, ON
P7L 0B4
(807)577-8182
Fax: (807)475-7662

The information to be disclosed relates to services beginning ________________ and ending __________________.
Related to which injury: ____

Medical History Summary	Medication List	Physical Therapy Report
X-Ray/MRI	Test Results	Surgical Report
Discharge Summary	Other:	Other:

The purpose of disclosure ("Request of the Individual" is sufficient for patient-initiated releases)

______Request of Individual*	Other:

*Patient to check off

CONDITIONS and NOTIFICATIONS:
This authorization for release of information expires 90 days from the date of the patient’s signature. You may revoke this authorization at any time by writing to the Office Supervisor at the address listed above. However, such notification will not affect any actions taken in reliance on this authorization prior to the time of receipt of the revocation. You may inspect or request a copy of the health information being used or disclosed, consistent with federal law. This Authorization is being given to the RRCC practice identified above.
NOTE: There may be a processing fee charged to the patient to cover labor, copying, and supplies used to reproduce medical records.

SIGNATURES:
I hereby authorize the use or disclosure of the personal health information as described above. I understand that I may refuse to sign this authorization, that this authorization is voluntary and that my health care and the payment for my health care will not be affected if I do not sign this form. I also understand that if the individual or organization authorized to receive the information is not a health plan or health provider, the release of information may no longer be protected by federal privacy regulations and, therefore, may be subject to re-disclosure.

____
Patient Name Print

____ Date: ________________________
Patient Signature

____
Witness Print

____ Date: ________________________
Witness Signature

Released by: ________________________________ Date: _________________________
(Department Representative Name)

** Please be aware your Clinic or Hospital may charge a fee for your records.

** **In the interest of saving trees, please send limited printed records. Only highlight the diagnosis of patient. The entire patient file is not required or preferred. (Fax is preferred)**