
Authorization and Direction

This is to authorize you to furnish _____ in the care of AMP Clerks, with all documentation which they may request from you from time to time regarding information in my file comprising the medical record, including but not limited to consultation reports, medical opinions, hospital admissions, progress reports, discharge reports, handwritten clinical notes and records, nurses' notes, X-ray results, MRI results, CT Scan results, reports of diagnostic tests, ambulance reports, etc. for the purposes of personal record keeping and/or to allow me to rapidly access consolidated medical records.

I have voluntarily enrolled to receive the services offered by AMP Clerks and I consent to communication between myself and/or AMP Clerks and/or _____ and/or the provider regarding matters related to this request. I have read AMP Clerks privacy policy, available at <https://ampclerks.com/privacy-policy/>. I have read AMP Clerks Terms and Conditions, available at <https://ampclerks.com/term-conditions/>. I acknowledge it contains information regarding the risks of email communication. I hereby consent to the use of email communication between AMP Clerks and/or _____ the provider and/or myself to fulfill this request.

I am aware of the risks and benefits of consenting or refusing to provide consent and that I can withdraw consent in writing at any time by mail, fax or email to AMP Clerks.

I CONSENT TO DISCLOSURE OF THE PATIENT'S PERSONAL HEALTH INFORMATION TO:

c/o AMP Clerks

Phone: (833) 903-2162

P.O Box: 102
Welland, ON, L3B 5Y5
Canada

Email to: administrator@ampclerks.com

SIGNATURE OF PATIENT OR SUBSTITUTE DECISION MAKER (SDM):

Witness Signature

Signature of Patient/SDM

Witness Name

Name of Patient/SDM