March 2023.

Dr. Muhammad Akmal Mushtaq
315 Pembroke Street East.
Pembroke, Ontario. K8A 3K2

Dear Valued Patient

I have been working in Pembroke Since Late 2017 and it has been an extreme pleasure and honour for me and my dedicated staff to serve you for all these years.

It is with tremendous difficulty to inform you that I will be closing my practice of medicine in Pembroke on June 14th, 2023

To begin the process of securing new family physician I encourage you to contact Health Care Connect and also try to speak to other doctors in the area who may already be looking after your other family members to see if they have any extra space to accommodate you.

West Champlain family health team and local recruiters are also trying to bring more family physicians to the area.

After securing a new family physician please inform all health care professionals (emergency departments, specialists, labs, hospital and walk in clinics) with the name of your new physician. This will ensure that reports and results will be sent to your new family physician for review and follow up. All outstanding correspondences for lab work, imaging studies, etc. given by this office should be completed by the end of May 2023 for the results to be received and reviewed.

I have made arrangements with DOCUdavit Solutions for the storage and management of all patient's medical records. DOCUdavit Solutions will ensure the security and privacy of your medical records and will provide your new family physician with an electronic or paper copy of your file upon your request. The maximum charge is $95.00 each for the first 2 patients and $65.00 for each additional patient plus applicable taxes and shipping.

I would recommend that you obtain a copy of your complete record for review with your new physician.

Enclosed you will find a record transfer request with instructions. If you have any questions, please contact DOCUdavit Solutions directly by phone at 1-888-781-9083, fax at 1-866-297-9338 or by email to: medicalrecords@docudavit.com
Please note that every individual over the age of nineteen must sign the document, this is required to ensure the privacy of records.

Thank you for the opportunity to be a partner in your medical care and I extend my best wishes to you for continued health.

Kind regards

Dr. Mushtaq

DOCUdavit Medical Solutions

CERTIFIED QUALITY SYSTEM - ISO 9001:2008 CERTIFIED INFORMATION SECURITY MANAGEMENT SYSTEM - ISO 27001:2013

Office Use Only – M – 595
Name: **Dr. Muhammad A. Mushtaq**
QC1:_____QC2: _____
Invoice:_____USB/PH/ONL:_____
Release:_____Shipper:_____
Arch. Box #:_____QC3:_____

PATIENT REQUEST FOR COPY and/or TRANSFER OF MEDICAL RECORDS

DOCUdavit Solutions Inc. ("DOCUdavit") has been authorized by **Dr. Muhammad A. Mushtaq** to receive and store, as his designee, and on his behalf, his patients' medical records, including but not limited to charts, laboratory tests and/or specimen results and reports, mental health records, drug and/or alcohol abuse records, HIV test results and any other material whatsoever concerning or related to your examinations, diagnosis or treatment (collectively, the "Medical Records"). In addition, **Dr. Muhammad A. Mushtaq** has authorized DOCUdavit to provide and/or transfer copies of the Medical Records when requested by the patient. Please be advised that the cost of obtaining and/or transferring copies of your Medical Records 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. Muhammad A. Mushtaq,** your Medical Records must be kept by DOCUdavit for at least 10 years after your last professional visit to **Dr. Muhammad A. Mushtaq** or, in the case of a minor, for at least 10 years following the minor's eighteenth birthday.

If you are interested in receiving and/or transferring a copy of your Medical Records on **USB**, **paper or online**, please complete the attached Direction/Authorization, and return it to the office of DOCUdavit Solutions. **PLEASE NOTE: The Direction/Authorization must be completed and signed by each adult over the age of 18.**

This service is not an insured service, and you must therefore attach payment for this service as set out below. The charge for duplicating and/or transferring your Medical Records is in accordance with your *Provincial Medical Association* or as otherwise directed by or as required by applicable law. However, DOCUdavit has capped the cost as follows:

As a courtesy to patients, we are reducing the fee for Paper/USB requests received by July 14, 2023, additional fuel surcharge will apply.			
Delivery Format:	**Online**	**Paper/USB**	
Availability:	**Anytime**	**Before**	**After**
	$5.00 Discount	**July 14, 2023**	**July 14, 2023**
1 Patient (MAXIMUM CHARGE $95.00 + $12.35 HST ON)	**$101.70**	**$126.70**	**$132.35**
2 Patients (MAXIMUM CHARGE $190.00 + $24.70 HST ON)	**$203.40**	**$228.40**	**$239.70**
Additional patients after 2 (MAXIMUM CHARGE $65.00 + $8.45 HST ON)	**$67.80**	**$67.80**	**$73.45**
***Cost is based on OMA suggested rates: Basic fee of $30.00 for the first 20 pages and $0.25 per page thereafter.**			
Shipping is provided by courier and requires a signature of receipt upon delivery.			

Please complete sections 1- 5 of this form and return it by Email, Fax, or Mail. **WE CANNOT PROCESS AN INCOMPLETE FORM.**

1. **Please select how you would like to receive your medical records.**
   IMPORTANT: ***If you do not make a selection, you will receive your records printed on paper.***

   ☐ Transfer my medical records **on-line** **OR**
   ☐ Transfer my medical records on a **USB** **OR**
   ☐ Transfer my medical records printed on **paper**

2. **Please indicate your choice of payment option with a check mark and return this form, completed to our office by Mail:** DOCUdavit Solutions Inc. P.O. Box 58045, RPO Dufferin, North York, ON. M6A 3C8 or **Fax:** 1-866-297-9338

   ☐ E-Transfer to medicalrecords@docudavit.com (Please include in message Patient 1 Full Name and former doctor's name)
   ☐ Cheque/Money Order included with this consent form. (Make Cheques payable to "DOCUdavit Solutions Inc." There is a $25 NSF fee)
   ☐ Credit Card Information included with this consent form.

   Credit Card Type: ☐ Visa ☐ MasterCard

   Credit Card Number:_____Expiry Date:_____

   Cardholders Name:_____

   Signature of cardholder_____ Date:_____

Requests are processed *within* four weeks from the date your records are received by DOCUdavit Solutions Inc.

*DOCUdavit Solutions Inc. Fees: DOCUdavit will collect fees for providing Patient Record Transfers according to your Provincial Medical Association recommended charges, or as otherwise directed by or as allowed by law, to the maximums specified in this Agreement. Cancellation of request subject to a $25.00 cancellation fee.

(SEE OVER)

DIRECTION / AUTHORIZATION **ON PH USB**

3. **(Please Print Clearly)**

	Last Name/ First Name/ Middle Name (Maiden Name)	Child <18	Date of Birth
PATIENT 1:		☐	MM/DD/YYYY
Patient 1 Email:			
PATIENT 2:		☐	MM/DD/YYYY
Patient 2 Email:			
PATIENT 3:		☐	MM/DD/YYYY
Patient 3 Email:			
PATIENT 4:		☐	MM/DD/YYYY
Patient 4 Email:			
PATIENT 5:		☐	MM/DD/YYYY
Patient 5 Email:			

For on-line access *your password and instructions on how to retrieve medical records will be sent to the e-mail address you have provided.*
Make *Minor's* records available under: ☐ Minor's Email **OR** under ☐ Adult Patient 1 **OR** ☐ Adult Patient2

Home Address:

Street No.		Street Name		Apt. No.		City	
Province		Postal Code		RR No.		P.O. Box	

Telephone Number(s):

I, _____ am the legal guardian for the above minor (under the age of 18) patient(s) of **Dr. Muhammad A. Mushtaq:**

4. I hereby direct and authorize **Dr. Muhammad A. Mushtaq** and DOCUdavit Solutions Inc. ("DOCUdavit") 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 records on-line to me (ensure you have included email address above), or**
- ☐ **Deliver to my Address**
- ☐ **Deliver to the Doctor named below**

New Doctor's Name: _____ **Doctor's Email Address:** _____

Doctors Address: _____ **Phone No.:** _____

☐ **Please transfer my records after the practice closes** *(select box if you are going to see **Dr. Muhammad A. Mushtaq** before **June 14, 2023**)*

5. I hereby release DOCUdavit and **Dr. Muhammad A. Mushtaq** from any and all legal liability that may arise as a result of the duplication and/or transfer of these Medical Records. Such legal liability may include, but not be limited to the loss or theft of these Medical Records when transferred in the form of a USB or paper copies. I understand that any and all information in these Medical Records shall be copied 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 DOCUdavit's and **Dr. Muhammad A. Mushtaq** full and sufficient authority for providing and transferring a copy of my Medical Records as indicated:

Patient 1 Signature (*or authorized individual*):_____Date:_____

Patient 2 Signature (*or authorized individual*):_____Date:_____

Patient 3 Signature (*or authorized individual*):_____ Date:_____

Patient 4 Signature (*or authorized individual*):_____Date:_____

Patient 5 Signature (*or authorized individual*):_____Date:_____

Comments:

Confidentiality Obligations: Except as otherwise provided in this Agreement, the Medical Records shall remain the exclusive property of **Dr. Muhammad A. Mushtaq**, and will only be used by DOCUdavit 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 DOCUdavit 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. DOCUdavit 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. The confidential information is not to be used, reproduced, transformed, or stored on a computer or device that is accessible to persons to whom disclosure may not be made, as set out in this Agreement.

Miscellaneous Personal Information: The patient consents to DOCUdavit's collection, use and disclosure of all personal information disclosed to DOCUdavit in this form, in the application process or in the ongoing administration of this Agreement. DOCUdavit will only collect, use 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 the Province of Ontario. DOCUdavit 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. Les parties aux presentes conviennent a ce document so it redige en anglais. This Agreement shall not become binding upon DOCUdavit until accepted by DOCUdavit. This Agreement is binding on the patient's heirs, executors, administrators, successors and permitted assignees. If more than one patient is named in this Agreement, the liability of each patient shall be joint and several. Clerical errors shall not affect the validity of this Agreement and DOCUdavit 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 DOCUdavit. DOCUdavit has created and implemented a privacy policy in compliance with PIPEDA and your Provincial Privacy Legislation to ensure that no personal information is collected, used or disclosed without the consent of the patient involved and/or **Dr. Muhammad A. Mushtaq**, or as otherwise required by law. This policy is available upon request. Time shall be of the essence of this Agreement.