X-RAY ASSOCIATES

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Consent for Disclosure of Personal Health Information

PATIENT INFORMATION

Patient's last name:	First:	Middle:

OHIP Number:	DOB: YYYY/MM/DD
Address: Street Name	Apt No.

City:	Province Postal Code:
Phone Number ( )	Alternate Phone Number: ( )

☐ To Obtain Information from:_____

And/OR

☐ To provide information to_____

REASON FOR REQUEST TO DISCLOSE PERSONAL HEALTH INFORMATION

I understand this information is to be used by the recipient for the purpose of:

☐ Self	☐ Health Care Provider	☐ Lawyer	☐ Insurance	☐ Other

PERSONAL HEALTH INFORMATION AUTHORIZED FOR RELEASE

Document(s) Required	Date of Visit(s)

Patient / Substitute Decision Maker/ Executor (print)	Signature	Date
Witness (Print)	Signature	Date

If the person signing is not the patient, please provide X-RAY ASSOCIATES with documentation of your authority to obtain this information.

FOR CLINIC USE ONLY

Clinic Fee:	Patient ID:

Processing of this request is subject to administration fees. This consent for release of patient information may be withdrawn by the patient, substitute decision maker or executor in writing at any time.

PLEASE FORWARD TO X-RAY ASSOCIATES HEAD OFFICE

HEAD OFFICE FAX # 289-553-5042