EFW Radiology
Specialists In Diagnostic Imaging

efwrad.com

Consent to Release Health Information

The patient must complete this form, or a written equivalent, before EFW may disclose the patient's health information to someone else, unless authorized to disclose without consent under Alberta's Health Information Act (HIA). Ask your Privacy Officer if unsure.

Mail to: EFW Radiology, c/o Patient Records, 312 3883 Front Street SE, Calgary, Alberta T3M 2J6, Canada; Fax: 403-541-0006; Email: patientrecords@efwrad.com

Patient Information

Last Name	**First Name**	
Address		
City/Town	**Province**	**Postal Code**
Date of Birth (dd/mmm/yyyy)	**Personal Health Number**	

Details of Request

Please describe in detail the health information you're authorizing to be disclosed, including the type of information eg. Medical reports, and/or images and date(s) of tests performed.

I,_____(printed name) authorize EFW Radiology to disclose my personal health information as described above to:

Name of Individual or Organization		
Address		
City/Town	**Province**	**Postal Code**
Purpose of Disclosure		

I understand why I am dislosing my individually identifying information. I am aware of the risks and benefits of consenting, or refusing to consent, to the disclosure of my health information. I understand that I may revoke this consent in writing at any time.

Effective Date (dd/mmm/yyyy)	**Expiry Date (dd/mmm/yyyy)** (valid for 1 year if no date provided)	
Name of Person Consenting	**Signature**	**Date (dd/mmm/yyyy)**
Witness Name	**Signature**	**Date (dd/mmm/yyyy)**

The personal information on this form is collected under Part 3 of the Health Information Act. If you have any questions about EFW's collection and use of your personal information, contact EFW Radiology's Privacy Officer at 587-470-6449 or email privacy.officer@efwrad.com.