Department of Medical Imaging
Authorization for Release of Personal Health Information

ST. MICHAEL'S UNITY HEALTH TORONTO

Pursuant to the Personal Health Information Protection Act, 2004 (PHIPA)

Office use only

MRN#:

Please complete the information in this section

Patient Name:_____ Date of Birth:_____
Last Name Given Name

Address:_____
Street City Province Postal Code

Phone#:_____ Health Card Number:_____

Exam/Image Requesting:_____
Example: CT, MRI, Ultrasound, X-Ray, Nuclear Medicine, Angiography/Interventional, X-Ray, etc.

Date(s) Exam Performed: _____

Destination:_____Fax #: _____
(Where are image records going? Example: Medical Facility, Physician, Specialist).

Patient Signature:_____Date:_____

Delegate information only - Delegate implies someone other than the patient is picking up the Imaging Record

If you are sending a delegate you must complete this section and the section above. Please ensure you (patient) have signed the form in the above section. Your delegate must provide valid photo identification in order to process this request.

Delegate Name:_____ Phone #:_____
Last Name Given Name

Delegate Signature:_____Date:_____

Office use only - Delegate verification (if applicable) and completion of request

*Valid Photo Identification Provided:*_____ *Letter of consent received (if applicable):*_____
Staff Initials *Staff Initials*

*Patient/Delegate acknowledges receipt of the correct Imaging Record :*_____
Initials

MI Staff confirms delivery of correct Imaging Record : _____*Documents scanned:*_____
Staff Initials *Staff Initials*

This request for patient records is made with implied consent, solely for the purposes of providing healthcare or assisting in providing healthcare for the above-named patient. There is no information that the patient has expressly withheld or withdrawn their consent to this disclosure (PHIPA section 18(3)(b)).