St. Michael's

Inspired Care.
Inspiring Science.

Medical Imaging

Release of Information Form

Patient's Name: Last name: _____First name_____

Address: _____

_____

Telephone #: Res.: _____Bus:_____

Patient's Delegate Information:

(Provide Valid ID)

(If the patient is unable to pick up on their own record)

Name: _____

Address:_____

_____

Telephone: _____

Relationship to patient: _____

Destination :

Medical Facility:_____

Name Of Physician:_____

Telephone: _____

Full address: _____

_____

Reason for request _____

(Office use only!)

(CD) (DVD) (FILM)

FL Clerks Initial_____

Please note: A CD will only be provided if images are required by your health care practitioner outside of St. Michaels Hospital (1)

For all media requests (CD's, DVD's, and Film) please read and sign below. **(2)**

Part I

I hereby waive all claims against the said Hospital, its doctors, employees and agents for all purposes whatsoever in connection with said communication and disclosure of information in the said record.

Part II

In those instances where electronic media or films are released to a delegate appointed by the patient, or to a doctor, lawyer or chiropractor of the patient's choice as so indicated by signed, witnessed consent, the letter of consent shall suffice as permission to release the said electronic media or films, and section (c) Part I, paragraph 2 remains in effect.

Date: _____

Signature: _____

Witness:_____

(1) ***Do not return electronic media to St. Michael's Hospital***

(2) ***The electronic media and the data it contains is the property of the patient.***