NORTH YORK GENERAL

DEPARTMENT OF MEDICAL IMAGING

CONSENT FOR RELEASE OF PERSONAL HEALTH INFORMATION

Form 000390 Rev. 10/2016

Film Library
General Site
4001 Leslie Street
Toronto, Ontario M2K 1E1
Tel 416-756-6169

Film Library
Branson Site
555 Finch Avenue, West
Toronto, Ontario M2R 1N5
Tel 416-633-9420 Ext 6515

PATIENT INFORMATION

*Last Name:	*First Name:
*Health Card Number or MRN:	*Date of Birth: DD MMM YYYY
Contact #: Area Code Number Ext.	

REASON FOR REQUEST AND RELEASE OF INFORMATION

Ensure images requested are not locked up in either the Actual Legal Cases or the Potential Legal Cases folders.

☐ Self ☐ Health Care Provider (including NYGH staff) ☐ Insurance ☐ WSIB ☐ Lawyer ☐ Other (please indicate):

If not for self, the undersigned hereby requests North York General Hospital to release my personal health information to/from

*Name of Health Care Provider/Third Party/NYGH Staff:	*Name/address where previous Imaging done:
*Address:	*Address:
	*Previous Imaging:
*Postal Code:	*Doctor:
* Contact #: Area Code Number Ext:	* Fax #: Area Code Number

If the person signing is not the patient, please provide NYGH with documentation giving you authority to obtain this information. Processing of this request may be subject to administration fees.
Please allow 48 hours to process your request for CD pickup.

PERSONAL HEALTH INFORMATION AUTHORIZED FOR RELEASE

*Exam(s) Required:	Date of Exam(s):	
*Patient/SDM/Designate (state relationship): **To be completed when picking up CD**	*Signature:	*Date:
*NYGH employee witness (print):	*Signature:	*Date:
*If other than patient, Type of Photo Identification: Example Driver's Licence or Health Card	Identification No:	

FOR INTERNAL USE ONLY

☐ Cash ☐ Cheque ☐ Debit ☐ VISA ☐ Mastercard ☐ American Express

*Total Received: _____ *Received By: _____ *Date: _____

*Mandatory fields

White Copy: Medical Imaging, Cardio/Respiratory