

Medical Imaging - Film Library
Release of Information Form



Leading with Innovation
Serving with Compassion

ST. MICHAEL'S HOSPITAL
A teaching hospital affiliated with the University of Toronto

Patient's Name: Last name _____ First _____

Address: _____

Telephone # Res.: _____ Bus: _____

Patient's Delegate Information Name: _____

(Must Provide Valid ID) 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 is only required if images are requested by your health care practitioner outside of St. Michaels Hospital

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

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: _____

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

*****: The electronic media and the data it contains is the property of the patient. *****