Patient Consent to Release of Information

Concerning Insurance/WSIB/Med-Legal Test Information

Patient Name_________________________________ Claim/ Reference No.__________________

Name of Insurer/ Employer/ Law Office requesting test: ____

Testing Arranged By:
MRI Appointments
York, ON N0A 1R0

Tel: 905 765 2620 Toll Free: 1 866 899 4674
Fax: 905 765 7099 Toll Free: 1 866 307 1247

Copies of the report to be sent to by fax:

1) MRI Appointments - fax- 1 866 307 1247

2) ______________________________________

I understand that MRI Appointments receives a copy of my report to send to ______________________

I authorize St. Joseph's Healthcare Hamilton to release my medical imaging results to the entities named above. The medical imaging test in question is:_________________________, performed on or between these dates:____.

I understand that if I withdraw my consent my exam will automatically be cancelled.

I also understand that every hospital or health facility that provides health care to a worker claiming benefits under the WSIB Insurance plan shall promptly give the Board such Information relating to the worker as the board may require. (Section 37, Workplace Safety and Insurance Act.).

Patient Authorization:

Name: ___________________________________ Date: ________________________

Authorized Signature ____

Please Note:

In Ontario: This test qualifies for third-party funding because the information provided is required for insurance purposes or medical-legal reasons and qualifies as an uninsured service as defined by the Ontario Health Insurance Act (Ontario Regulation 552 Par 8 and Par 24) or the Workplace Safety Insurance Act.