Patient Release of Information
(Uninsured Services)

Patient Name_____ Claim/ Reference No._____

Name of Insurance Company/ 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 authorize St. Joseph's Heathcare Hamilton to release my medical imaging results to the entities named above.

_____

Patient Authorization:

Name: _____ Date: _____

Authorized Signature _____

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.