Oxford
MEDICAL IMAGING

# CONSENT FOR DISCLOSURE OF PERSONAL HEALTH INFORMATION

I, _____, hereby authorize Oxford Medical Imaging to
(Patient Name: Print Last Name, First Name)

disclose personal health information to _____,
(Name of facility requesting information)

of, _____
(Street Address, City, Province)

From the records of: _____
(Patient Name)

_____
(Date of Birth) (HIN)

I consent to the following information to be disclosed (please check all the apply):

☐ Imaging Media (CD/DVD/film) ☐ Medical Reports ☐ Other (please specify):

This information is being released for the purpose of:

_____

Additional Instructions:

_____

**THIS AUTHORIZATION MAY BE WITHDRAWN IN WRITING AT ANY TIME**

PLEASE PRINT NAME CLEARLY, DATE AND SIGN

_____
Patient's Name Date

_____
Signature of Patient/Authorized Representative

(If other than patient, print name, state relationship and provide an authorization letter which is signed and dated by the patient)