Patient Authorization for Release of Information

Consent to Disclose Personal Health Information
Pursuant to the Personal Health Information Protection Act, 2004 (PHIPA)

I, _____, authorize London X-Ray Associates____
(Patient's name)*

to disclose my personal health information consisting of:

_____

_____
(Describe the personal health information to be disclosed – IE: type of exam(s) and possible dates)

Patient Information

Patient Name: _____
Date of Birth: _____
Contact Telephone#: _____
Health Card#: _____ Version Code: _____

Patient Signature*: _____
Date: _____
Witness Name (Print): _____
Witness Signature: _____

*Please note: A substitute decision-maker is a person authorized under PHIPA to consent, on behalf of an individual, to disclose personal health information about the individual.

Requesting Office Information: (use your stamp or label if available)

Clinician Name: _____
Clinician Address: _____
Clinician Phone: _____ private# preferred for call back if req'd
Patient ID # (if available): _____

LXA InteleConnect: Clinician's Portal https://pacs.lxa.on.ca/portal

Patient images and reports are available for secure online viewing via our Clinician's portal.
Do you require online access of these exam images and reports via our Portal?
YES _____ NO _____ ***We will create an account for you if one does not exist.***

We can send you a notification via email, addressed to the requesting clinician.
Please provide your email address (print):_____

PLEASE FAX TO LONDON X-RAY ASSOCIATES AT: 519-672-2724
We may require up to 24 hours to complete this request. Thank you.