FOOTHILLS FAMILY MEDICAL CENTRE

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Consent for Disclosure of Identifying Health Information

I, _____ give consent for

Dr. _____ of Foothills Family Medical Centre to disclose:

☐ **Complete Chart **** **(Please specify time frame - _____)**
☐ **Lab Results** **(Please specify time frame - _____)**
☐ **Diagnostic Imaging (Xray, ultrasound, CT, MRI, mammogram, etc)**
☐ **Other** _____

to _____
(identify individual/organization to whom information is released)

for the purpose of _____.

I acknowledge that I have been made aware of the reasons for the disclosure of the above information, and the risks and benefits associated with consenting to its release. I understand that I may revoke my consent at any time by providing a signed, written statement to that effect.

Dated this _____ of _____, _____.

Day Month Year

Signature: _____

Print Name: _____

****Fees may apply**