FOOTHILLS FAMILY MEDICAL CENTRE

J.M. BISHOP, M.D. C.C.F.P.
J.V. BRANCH, M.D.*, C.C.F.P.
B.J. DORAN, M.D.*, C.C.F.P
T. J. DOWDALL, M.B.*, C.H.B. C.C.F.P.
N. W. GRISDALE, M.D.*, C.C.F.P
T.C. HEMBROFF, M.D*, C.C.F.P.
J. LEMIRE, M.D,C.C.F.P

E. JABLONSKI, M.C.*, C.C.F.P.
C. POCOCK, M.C.*, C.C.F.P.
G. J. RAY, M.D.*, C.C.F.P..
Y. KORCHEMAGIN, M.D.*,C.C.F.P.
M.J. SCHUCK, M.D., C.C.F.P.
B. L. SIRAY, M.D.*, C.C.F.P
A. VAN AERDE, M.D.*, C.C.F.P.

*PROFESSIONAL CORPORATION

P. O. BAG 460
114 1st SW

Black Diamond AB T0L 0H0
Phone: (403) 933-4368
Fax: (403) 933-2026
Email: clinic@ffmc.ca

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**