

Request to Access Health Information

This form is to be filled out by the patient requesting access to their own personal information held by EFW Radiology in accordance with Alberta's Health Information Act (HIA).

Mail to: EFW Radiology, c/o Patient Records, 312 3883 Front Street SE, Calgary, Alberta T3M 2J6, Canada;
Fax: 403-541-0006; Email: patientrecords@efwrad.com

Patient Information			
Last Name		First Name	
Address			
City/Town	Province	Postal Code	
Date of Birth (dd/mmm/yyyy)	Alberta Health Care Number	Telephone Number	
REQUIRED INFORMATION Clinic Location for Pickup (Checkbox)			
☐ AIRDRIE	☐ BEDDINGTON	☐ CAMBRIAN	☐ GULF CANADA SQUARE
☐ SETON	☐ SOUTHPORT	☐ SUNRIDGE	☐ UXBOROUGH

Details of Request
Please describe in detail the health information you are requesting we disclose to you, including the type of information e.g. Medical reports, and/or images and date(s) of tests performed. Attach additional pages if needed.
How would you like to receive disclosure of the records? Check the correct box
☐ I'd like a CD for my doctor ☐ A USB for myself- FEE FOR USB IS: \$10.00 ☐ A printed report ☐ Mail the records to the address on this form

Your Signature	Date (dd/mmm/yyyy)
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