EFW Radiology
Specialists In Diagnostic Imaging

efwrad.com

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**

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 & in what form? Check the correct box(s)

☐ I'd like a CD for my doctor, OR,
☐ A USB for myself, OR, FEE FOR USB $10
☐ A printed report
☐ Mail the records to the address on this form, OR,
☐ I will pick up the records at the (identify the EFW clinic by name)_____clinic

Your Signature	**Date (dd/mmm/yyyy)**

The personal information on this form is collected under Part 3 of the Health Information Act. If you have any questions about EFW's collection and use of your personal information, contact EFW Radiology's Privacy Officer at 587-470-6449 or email privacy.officer@efwrad.com