Authorizing a Representative

Health Information Act (HIA)
Personal Information Protection Act (PIPA)

The applicant or their authorized representative must complete this form before Mayfair may disclose the applicant's response and associated records to someone else (unless Alberta's Health Information Act authorizes disclosure without consent). **Please submit your completed form by:**

Mail: Mayfair Diagnostics, Privacy Officer
132 – 6707 Elbow Dr. SE,
Calgary, AB T2V 0E3

Fax: 1.403.777.3008

In person: Drop off in person in a sealed envelope addressed to Mayfair Privacy Officer at any of our clinic locations.

For questions on how to complete this form, contact Mayfair's Privacy Officer at 403.385.0265 or email privacy@radiology.ca.

APPLICANT INFORMATION

Last name: ______________________________ First name: ______________________________

Mailing address: ____

City or town: ______________________ Province: __________ Postal code: ______________

Date of birth (day/month/year): _____ /_____ /_______ Organization (if applicable): ____________________

REPRESENTATIVE INFORMATION

Last name: ______________________________ First name: ______________________________

Mailing address: ____

City or town: ______________________ Province: __________ Postal code: ______________

Date of birth (day/month/year): _____ /_____ /_______ Organization (if applicable): ____________________

Representative is authorized to: *(check one)*

- ☐ Exercise all my rights under the *Health Information Act.*
- ☐ Exercise my right to access all my records contained in my request.
- ☐ Exercise my right to access only the following records contained in my request. *(Describe):*

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- ☐ Other: *(Describe in detail.)*

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☐ **I confirm that my representative has the authority to carry out the above rights and responsibilities on my behalf.**

Name: *(Print last name, first name)* ____

Signature: ____

Date (day/month/year): _____ /_____ /___________ Expiry date (day/month/year): _____ /_____ /___________

Witness last name: ______________________________ Witness first name: ______________________

Witness signature: ____

Personal information on this form is collected under division 3 of the Personal Information Protection Act.
If you have questions about Mayfair's collection and use of your personal information, please contact Mayfair Privacy at 1.403.385.0265 or email ***privacy@radiology.ca.***

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