

Authorizing a Representative

MAYFAIR[®]
DIAGNOSTICS

Health Information Protection Act (HIPA)

Personal Information Protection and Electronic Documents Act (PIPEDA)

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 Saskatchewan's Health Information Protection 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 Protection 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):*

Other: *(Describe in detail.)*

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: _____