PUREFORM
RADIOLOGY

MyPureform.com
403-726-9729

AUTHORIZATION TO RELEASE / REQUEST INFORMATION

I _____, authorize Pureform Radiology (on my behalf) to request and retrieve copies
Patient Name
of, and information related to my prior medical exams. This may include medical information including registration information, medical reports, diagnostic images and other diagnostic treatment and care information.

Pureform may use this information for reference and comparison purposes during your upcoming medical exam(s). Pureform collects this information in accordance with the Alberta Health Information Act and other applicable legislation.

To facilitate the collection of medical your records please complete the form below.

Last Name		**First Name**	

By Signing below, I authorize Pureform to retrieve the aforementioned medical information.

Signature		**Date**	