# Diagnostic Imaging Common Service Inquiries and Complaints Request for Service Form

INSTRUCTIONS TO THE PERSON MAKING THE REQUEST:

- Please complete this form with as much information as possible. Fields indicated with an asterisk (*) are mandatory fields. This will help eHealth Ontario fulfill your request.
- Mail or fax the completed form to:
  - Mail: eHealth Ontario Privacy Office P.O. Box 148, 777 Bay Street, Suite 701, Toronto, Ontario, M5G 2C8
  - Fax: (416) 586-4397 or 1 (866) 831-0107
- Please do not use email to submit this form.
- If you have questions about this form, contact the eHealth Ontario Privacy Office at 416-946-4767 or email contact Privacy@ehealthontario.on.ca with your name and phone number.

| REQUESTOR'S CONTACT INFORMATION | | |
|---|---|---|
| *(To be completed by person making the request)* | | |
| *First Name: | *Last Name: | |
| *Mailing Address: | *Title: | |
| *City: | *Province: | *Postal Code: |
| *Preferred Phone: | | |
| Relationship: ☐ Patient ☐ Substitute Decision Maker | | |
| Preffered Method of Contact: ☐ Mail ☐ Telephone | Permission to leave voicemail ☐ Yes ☐ No | |

| PATIENT INFORMATION | |
|---|---|
| *First Name: | *Last Name: |
| *Gender: ☐ Male ☐ Female | *Date of birth: MM/DD/YYYY |
| *Health Card Number: | |

| CONSENT |
|---|
| *(Allows patient's personal health information to be shared with other health care providers that contributed to your records in order to respond to your inquiry or complaint)* |
| ☐ I consent to the sharing of my personal health information with other health care providers to obtain information from DI Common Services |
| ☐ I DO NOT want my personal health information to be shared with other health care providers. |

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| INQUIRY (Indicate details of inquiry): | |
|---|---|
| | |
| **COMPLAINT** (Indicate details of complaint): | |
| | |
| **SIGNATURE** | |
| Name (Print) : | Date: MM/DD/YYYY |
| Signature: | |
| **FOR OFFICE USE ONLY (Do Not Complete)** | |
| Form Completed: ☐ Yes ☐ No | Remedy Ticket # |
| | |
| Notes: | |