



THERMOGRAPHY CLINIC MILTON INC
 400 Bronte Street S., Suite 215
 Milton, ON L9T 0H7
 (905) 781-2447

RELEASE & CONSENT TO COLLECT/SHARE PRIVATE INFORMATION

Date: _____ **Date of Birth** _____ / _____ / _____
 mm / dd / yyyy

Name: _____

Street: _____ **City:** _____

Province: _____ **Postal Code:** _____

Infrared Imaging is a non-contact, non-invasive test that demonstrates physiological patterns of your body. It is not a stand-alone diagnostic test and does not replace or discourage clinical findings, mammography, or any other structural examinations. The information provided by your thermal imaging is combined with your history to enable your health care provider to plan an approach to your care.

A licensed medical practitioner is the only qualified person to formulate a diagnosis. He or she must combine thermographic studies with your additional clinical and testing information to determine your problem. Infrared scans provide evidence of thermal asymmetries that may be present. An asymmetry may be indicative of a vascular, neurological, muscular or other physiological problem.

I have read the above information and understand that I am not receiving a diagnosis of any condition based solely on my thermal scan. I understand that a thermal scan is not invasive, and is a reading of thermal patterns on the surface of the body. From this information a qualified practitioner will interpret any thermal abnormality displayed.

Print & sign your legal name: _____ **Date:** _____

Signature of scanning technician: _____ **Date:** _____

Consent to Disclose Personal Health Information Pursuant to the Personal Health Information Protection Act, 2004 (PHIPA)

I, (Print your name) _____, authorize Thermography Clinic to disclose:
 The information contained in my thermography imaging report(s) to:

 (Print name, phone and email address of person requesting the information)

I understand the purpose for disclosing this personal health information to the person noted above. I understand that I can refuse to sign this consent form.

Signature: _____ **Date:** _____

Witness Name: _____ **Signature:** _____ **Date:** _____