Health Services

Health Services, Room C141 (C Building)
Algonquin College
1385 Woodroffe Ave
Ottawa, ON K2G 1V8
Phone: 613.727.4723 ext. 7222
Fax: 613-727-3166

CONSENT FOR DISCLOSURE OF PERSONAL HEALTH INFORMATION

PURSUANT TO THE PERSONAL HEALTH INFORMATION PROTECTION ACT, 2004 (PHIPA)

I authorize ALGONQUIN COLLEGE HEALTH SERVICES to disclose my personal health information to:
Name of Person/Agency ______________________________
Address/Phone/Fax ______________________________

I consent to the following specific information to be disclosed (please check all the appropriate items):

- ☐ Complete chart
- ☐ Labratory reports
- ☐ Diagnostic imaging reports
- ☐ Pap test results
- ☐ Consult notes/reports
- ☐ Immunization records
- ☐ Other (please specify):

How may this information be released (choose all that apply):

- ☐ Copy sent by Fax
- ☐ Copy Sent by Regular Mail
- ☐ Copy Picked Up in Person

***Please note medical records may not be sent by electronic mail or other electronic means**

Additional comments; instructions

The purpose for this diclosure is as follows:

- ☐ Transfer to new Physician
- ☐ Other (please specify purpose): ______________________________

THIS CONSENT:

- ☐ Is valid for 12 months from the date of signature
- ☐ Is valid for this request only
- ☐ Expires on: ____________________

I UNDERSTAND THE PURPOSE FOR DISCLOSING THIS PERSONAL HEALTH INFORMATION TO THE PERSON OF THE ORGANIZATION NOTED ABOVE. I UNDERSTAND THAT I CAN REFUSE TO SIGN THIS FORM. I UNDERSTAND THAT I CAN WITHDRAW THIS AUTHORIZATION AT ANY TIME BY NOTIFICATION IN WRITING TO ALGONQUIN COLLEGE HEALTH SERVICES.

Signature of Patient

Signature of Witness

Print name of Patient

Print name of Witness

Date (dd/mm/yyyy)

***Please note that administrative fee applies for chart transfers**

HS Patient Label