Health Services

Health Services, Room C141 (C Building)
Algonquin College
1385 Woodroffe Ave
Ottawa, ON K2G 1V8
Phone: 613.727.4723 ext. 7222
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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
- ☐ Copy sent by Email

***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

_____
Print name of Patient

_____
Date (dd/mm/yyyy)

HS Patient Label

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