



The Ottawa Hospital

- Civic HI
- General TRC
- Riverside TOHCC

REQUEST/CONSENT FOR RELEASE/DISCLOSURE OF PATIENT HEALTH INFORMATION

health rec. no.

last name

first name

health insurance no.

d.o.b.

sex

How will the information be released? Paper copy CD Online

To: (Requester's address, phone number, and email address for Online Releases)

INFORMATION

DATE RANGE FOR REPORTS / OTHER COMMENTS

- Discharge Summary _____
- Operative Reports _____
- Pathology Reports _____
- Anaesthesia/Recovery Room _____
- Medical Imaging _____
 - Report Only _____
 - CD of Images _____
- Laboratory Reports _____
- Consultation/Progress Notes _____
- ER Record _____
- Chart Copy _____
 - Details: _____
- Confirmation of Dates _____
- Proof of Death _____
- Family Health Team Reports _____
- Other: _____

Comments / Details:

PLEASE NOTE ALL FEES FOR RELEASE OF INFORMATION ARE NON-REFUNDABLE.

CONSENT FOR RELEASE OF PATIENT HEALTH INFORMATION

Patient consent must be obtained for disclosing personal health information to a third party (e.g. Lawyer, Ins Co.) or if the request is related to information from a health care organization located outside the province of Ontario.

I authorize The Ottawa Hospital to release/obtain the information noted above.

| | | |
|---|-----------|-------------------|
| Name of patient/substitute decision maker | Signature | Date (yyyy/mm/dd) |
|---|-----------|-------------------|

| | | |
|-----------------|-----------|-------------------|
| Name of witness | Signature | Date (yyyy/mm/dd) |
|-----------------|-----------|-------------------|

Authorization is valid for 1 year from date of signing. Include copies of documents providing your authority as a substitute decision-maker.

| | | |
|--|-----------|--------------|
| HEALTH RECORDS USE ONLY: Date received: | TOTAL \$: | Received by: |
|--|-----------|--------------|