The Ottawa Hospital

❑ Civic ❑ HI
❑ General ❑ TRC
❑ Riverside ❑ TOHCC

REQUEST/CONSENT FOR RELEASE/DISCLOSURE OF PATIENT HEALTH INFORMATION

Last name: _____

First name: _____

Date of birth: _____ Sex: _____

Health Card # (optional): _____

How will the information be released? ❑ Paper copy ❑ MyChart ❑ Email (Secure Link)
To: (Requester's address, phone number, and email address for Online Releases)

_____

_____

Instructions: Please complete Section A OR Section B

Section A

❑ All Records from **After** November 2009 **AND/OR** ❑ All Records **Prior** to November 2009*
*These are paper-files and may incur additional processing fees as per our fee schedule or take additional time to process

Section B

INFORMATION	DATE RANGE FOR REPORTS / OTHER COMMENTS
❑ Discharge Summary	
❑ Operative Reports	
❑ Pathology Reports	
❑ Laboratory Reports	
❑ Anaesthesia/Recovery Room	
❑ Consultation/Progress Notes	
❑ ER Record	
❑ Medical Imaging* (images available free at www.pockethealth.com)	
❑ Report Only ❑ CD of Images	
❑ Confirmation of Visit Dates for Taxes	
❑ Proof of Death	

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.