The Ottawa Hospital | L'Hôpital d'Ottawa

- ❑ Civic
- ❑ General
- ❑ Riverside
- ❑ HI
- ❑ TRC
- ❑ RCC

REQUEST/CONSENT FOR RELEASE/DISCLOSURE OF PATIENT HEALTH INFORMATION

health rec. no.

last name

first name

health insurance no. d.o.b. sex

INFORMATION TO BE ❑ Paper copy ❑ CD
TO: (Requester's address and phone number)

INFORMATION	COMMENTS AND DATES
❑ 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

❑ 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: