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: