The Ottawa Hospital | L'Hôpital d'Ottawa

☐ Civic ☐ HI
☐ General ☐ TRC
☐ Riverside ☐ RCC

REQUEST/CONSENT FOR RELEASE/DISCLOSURE OF PATIENT HEALTH INFORMATION

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: