PRINTED VERSION ONLY - please print, complete by hand and deliver in-person to the CHWC

DURHAM COLLEGE SUCCESS MATTERS + CAMPUS HEALTH AND WELLNESS CENTRE

Consent for Access of Personal Health Information

2000 Simcoe St. N., Oshawa, ON L1G 0C5
Telephone: (905) 721-3037; Fax: (905) 721-3133

For more information or to request alternate formats of this form for accessibility or if you are a Substitute Decision Maker, please contact chwc@durhamcollege.ca

Questions about this form should be directed to Durham College Campus Health and Wellness Centre by email to: chwc@durhamcollege.ca

INDIVIDUAL AND PERSONAL HEALTH INFORMATION TO BE DISCLOSED

First Name: _____ Last Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone Number: _____ Date of Birth: _____

Email Address: _____

Please provide a detailed description of the personal health information you are requesting and details that will assist us in locating this information (eg. dates, name of health care provider, etc.)

Specify the reason for this request:

AUTHORITY TO REQUEST

I, _____ consent to the access of the specified personal health information by Durham College as described above.

RECORDS TO BE RELEASED TO

☐ same as requesting 'individual'

Preferred Transfer Format: _____

Preferred Method of communication: ☐ Telephone ☐ Email

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CONSENT TO RELEASE INFORMATION

☐ I have legal authority to consent to this access request as I am the individual whose personal health information is being accessed.

☐ I understand that I may withdraw my consent at any time, in writing to Durham College, as long as the Records have not already been released.

☐ I hereby waive any and all claims against Durham College, and their Boards of Directors, physicians, employees, officers, students and agents in connection with the access of my personal health information under this consent form.

☐ I understand that my consent under this form is valid for 120 days from date of signature and will expire thereafter.

Please note: proof of identification and/or a fee may apply that must be paid before the request is processed.

Date: _____ Patient Signature: _____

CAMPUS HEALTH & WELLNESS CENTRE

Durham College
2000 Simcoe St. N., Room G1030 Telephone: 905-721-3037
Oshawa, ON L1G 0C5 Fax: 905-721-3133
Receiving Clerk:
First Name: _____ Last Name: _____

Date: _____ Signature: _____

☐ Verified Government issued identification (if applicable)

NOTICE OF COLLECTION

Durham College is the health information custodian of all documentation and records submitted to or created by Durham College Campus Health and Wellness Centre. All records are maintained in accordance with applicable legislation, including the *Personal Health Information Protection Act, 2004* and the policies of Durham College.

The information collected on and under this form is collected by Durham College under the legal authority of section 2 of the *Ontario Colleges of Applied Arts and Technologies Act, 2002*.