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 to the Disclosure of Personal Health Information to Medavie Blue Cross

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

AUTHORITY TO REQUEST

I, _____ consent to the disclosure of my personal health information by Durham College to Medavie Blue Cross for the purpose of ascertaining my eligibility for insurance coverage.

INDIVIDUAL AND PERSONAL HEALTH INFORMATION TO BE DISCLOSED

First Name: _____ Last Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone Number: _____ Date of Birth: _____

Email Address: _____

Personal health information to be disclosed: Any personal health information requested by Medavie Blue Cross to ascertain my eligibility for insurance coverage

RECORDS TO BE RELEASED TO

Person/facility: Medavie Blue Cross (attn: Montreal Claims Dept)

Address: 1981 McGill College Ave, Suite 100

City: Montreal Province: QC Postal Code: H3A 3A7

Telephone Number: (514) 286-9833 Fax Number:

Transfer format: Secure email transfer

CONSENT TO RELEASE INFORMATION

☐ I have legal authority to consent to this disclosure as I am the individual whose personal health information is being disclosed.

☐ 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 disclosure of my personal health information under this consent form.

☐ I understand that my consent under this form is valid for 24 months from date of signature and will expire thereafter.

Date: _____ Patient Signature: _____

CAMPUS HEALTH & WELLNESS CENTRE – DELIVER FORM IN-PERSON TO:

Durham College
2000 Simcoe St. N., Room G1030
Oshawa, ON L1G 0C5

Telephone: 905-721-3037
Fax: 905-721-3133

Receiving Clerk

First Name: _____ Last Name: _____

Date: _____ Signature: _____

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*.