**ELECTRONIC VERSION ONLY - to be completed on a computer and emailed to the CHWC**

DURHAM COLLEGE SUCCESS MATTERS
CAMPUS HEALTH AND WELLNESS CENTRE

# Consent to the Disclosure of Personal Health Information to a Third-Party

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, 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: Select One 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:

## SUBSTITUTE DECISION MAKER (SDM) (IF APPLICABLE)

Person/facility:
Relationship to Individual: Select One
Address:
City: Province: Select One Postal Code:
Telephone Number: Fax Number:
Email address:

## AUTHORITY TO REQUEST

I, _____ consent to the disclosure of the specified personal health information by Durham College as described above to the 'Recipient of Records' identified below.

## RECIPIENT OF RECORDS

Person/facility:
Address:
City: Province: Select One Postal Code:
Telephone Number:
Email address:

## 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 or I have the authority to request such information as the SDM.

☐ 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 120 days from date of signature and will expire thereafter.

## DISCLAIMER

Upon completion of this form your request for disclosure of personal health information will be directly submitted to the Campus Health and Wellness Centre's email at chwc@durhamcollege.ca. Please be advised that submitting requests via email carries certain risks. While efforts have been made to secure the transmission of information, email communication may not be entirely secure. By sending your request via email, you acknowledge and accept the potential risks associated with electronic communication. Alternatively, you may choose to request a printed form from the clinic and deliver it directly to clinic reception staff.

Please consider the method of submission that best suits your preferences and risk tolerance.

By proceeding with your request via email or in-person delivery, you understand and agree to the terms outlined in this disclaimer.

☐ **By signing and submitting this form, I acknowledge and accept the potential risks associated with electronic communication.**

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

Date: Patient/SDM Signature:

## CAMPUS HEALTH & WELLNESS CENTRE OFFICE USE ONLY

Receiving Clerk:
First Name: Last Name:
Date: Signature:

Transfer Format: ☐ Email ☐ Hard Copy

## 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*.