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

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: __________________ 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: ____

Address: ____

City: _____________________ Province: __________________ 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.

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RECIPIENT OF RECORDS

Person/facility: ____________________

Address: ____________________

City: ____________ Province: ____________ 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.

Date: ____________ Patient/SDM 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: ____________________

Transfer Format:

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*.