Health & Counselling Services
Suite 2600 CTTC Building
1125 Colonel By Drive
Ottawa, ON K1S 5B6
Tel: 613-520-6674
Fax: 613-520-3851
hcs@carleton.ca

Release of Personal Health Information Authorization form

Name:
Address:
Phone:
Date of Birth: Gender: Health Insurance #

I hereby authorize Carleton University Health & Counselling Services to:
[ ] Transfer my medical records to:
[ ] Obtain my medical records from:
[ ] Discuss my medical information with:
[ ] Obtain a copy of my medical record(s):

Dr. / Medical Facility: ______________________________

Address: ______________________________

Telephone: ______________ Fax: ______________

Information Requested: ______________________________

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I understand that by signing this authorization:

- I authorize the use or disclosure of my individual health and/or counseling information as described above.
- I give this authorization voluntarily.
- I understand I have a right to receive a copy of this authorization.
- I understand that I may withdraw my consent at any time by giving written notice.
- I further understand that withdrawal of this consent shall not be retroactive.
- I declare that the information on this form is true and correct.

* There is a $30 minimum charge to have records transferred out.

______________________ ______________________
Signature Date

Date Completed & Initials: Received by Patient (Initals):

Carleton University endeavors to keep your personal information confidential and to handle it in accordance with Sections 18 &19 of the Personal Health Information Protection Act (PHIPA), S.O. 2001, c.3, Sched. A. The information provided will not be used for any purpose other than those stated upon this form unless the applicant provides consent. Should you have any questions concerning your personal information, please contact the Director of Health & Counselling Services.