Please complete, sign & return to the circled address/fax#

CONSENT TO DISCLOSURE OF PERSONAL OR HEALTH INFORMATION

FILL IN WITH BLACK PEN

I, ★ ____

AUTHORIZE ★ ____
Name of Facility (where testing or diagnosis was done)

____
Address

____
Telephone/fax #

TO DISCLOSE / FORWARD TO:

HEREDITARY CANCER PROGRAM
Children's Hospital of Eastern Ontario
Genetics Clinic – WC2
401 Smyth Road, Ottawa, ON K1H 8L1
Tel #: (613) 737-7600 x 3774
FAX: (613) 738-4822

THE FOLLOWING HEALTH OR PERSONAL INFORMATION (please specify):

- ✓ **Medical records confirming diagnosis of: CANCER**
- ✓ **Laboratory results, including: ALL SURGERY AND PATHOLOGY REPORTS**
- ❑ **Genetics consult note/letter**
- ❑ **Results of genetic testing/linkage testing**
- ❑ **Family tree/pedigree**
- ❑ **Other:**____

FROM THE HEALTH RECORD OF: ★ ____
PATIENT'S NAME

DATE OF BIRTH: ★ ______________________ **(day/month/year)** ***YEAR OF DIAGNOSIS*** **:** ______________________

I understand this consent may be withdrawn at any time, except where action has already been taken.

X ★ ______________________ ______________________ ★ ______________________
(Signature of Patient (over age of 16) or Substitute Decision Maker) **(Relation of patient)** **(Date)**

NOTE TO FACILITIES: PLEASE RETURN THIS FORM WITH ALL DOCUMENTS

FOR ADMINISTRATION USE

This request was made by: ***MRN/Genetics File #:***________________

Name: ______________________ ***Our Patient:*** ______________________