Children's Hospital of Eastern Ontario
Centre hospitalier pour enfants de l'est de l'Ontario

401 Smyth Road, Ottawa, Ontario, K1H 8L1

CONSENT TO DISCLOSURE OF PERSONAL OR HEALTH INFORMATION

(Please use a FORM 14 for release of psychiatric information)

I, ____

AUTHORIZE (name/address of facility releasing information)

____
Name of facility

____
Address

____
Telephone/fax #

TO DISCLOSE / FORWARD TO:
Children's Hospital of Eastern Ontario
Genetics Clinic – WC2
401 Smyth Road, Ottawa, ON K1H 8L1
Tel #: (613) 737-7600 x ___________
FAX: (613) 738-4822

OR :
____
____
____

THE FOLLOWING HEALTH OR PERSONAL INFORMATION (please specifiy):

- ❑ **Medical records confirming diagnosis of** ______________________________
- ❑ **Laboratory results, including**______________________________
- ❑ **Genetics consult note/letter**
- ❑ **Results of genetic testing/linkage testing**
- ❑ **Family tree/pedigree**
- ❑ **Other:**______________________________
____

FROM THE HEALTH RECORD OF:______________________________
(patient name)

DATE OF BIRTH: ______________________ **(day/month/year)** **Unique ID #:** ______________________

I understand this consent may be withdrawn at any time, except where action has already been taken.

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

PLEASE RETURN THIS FORM WITH ALL DOCUMENTS

FOR ADMINISTRATION USE

This request was made by:	*Genetics File #*______________________
Name: ______________________	*Patient:* ______________________
*On behalf of:*______________________	*Date:*______________________