UNIVERSITY OF CALGARY

Student Wellness Services

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ucalgary.ca

CONSENT AND DISCLOSE PERSONAL HEALTH INFORMATION HELD AT UNIVERSITY HEALTH SERVICES

CONSENT TO RELEASE

I ________________ authorize Dr./Mr./Ms ________________________________ @ University Health Services to release my medical records

Release Of:

- Chart Summary ________________
- Consultation Reports ________________
- Hospital Discharge Summary ________________
- Lab Reports ________________
- Operative Reports ________________
- X-Ray Reports ________________
- Other ________________

To: Dr./Mr./Mrs. ________________
or Authorized Representatives ________________
____
Ph: ________________
Fax: ________________

Re: ________________
____
Phone Number: ________________
Health Care Number: ________________

In accordance with the guidelines set out by the College of Physicians and Surgeons of Alberta, as well as the Health Information Act, University Health Services will be charging a fee for the transfer of complete medical record or a significant portion thereof. If transfer of a complete medical record or a significant portion thereof is required then there will be a charge of $25.00 plus .25/page for charts in excess of 25 pages. The College has indicated that the responsibility for this fee is that of the requesting physician or patient.

I understand that there may be a charge for this service and that I may be responsible for it.

I understand this consent will become part of my patient/client record.

I acknowledge that I have been made aware of the reasons for the disclosure of the above information, and the risks and benefits associated with consenting to its release.

I understand that I may revoke at any time, by providing a signed, written statement to that effect.

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Patient's Signature Date

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