

Release of Personal Health Authorization Form

Name:

Phone Number:

Address:

Email Address

Date of Birth:

Gender:

Health Insurance #

Student ID:

I hereby authorize Carleton University Health and Counselling Services to:

☐ RELEASE medical records to ☐ OBTAIN medical record from ☐ DISCUSS medical information with

Name of Individual, Doctor, or Medical Facility _____

Address: _____

Phone: _____ Fax: _____

Please fax all requested records to: **Carleton University Health & Counselling Services**

Attn: Dr. _____ Fax: 613-520-3851

Comments: _____

Please note that we do not release counselling notes.

☐ Encounter Notes

☐ All laboratory reports

☐ Immunization Records

☐ Diagnostic Imaging Reports

☐ All Past & Ongoing Medications

- I declare that the information on this form is true and correct.
- I further understand that withdrawal of this consent shall not be retroactive.
- I understand that I may withdraw my consent at any time by giving written notice.

- I understand I have a right to receive a copy of this authorization.
- I give this authorization voluntarily.
- I authorize the use or disclosure of my individual health and/or counseling information as described above.

I confirm this information is accurate and authorize future medical correspondence to be forwarded to my designated family physician as listed above.

Signature: _____ Date: _____

A \$30.00 fee is required before processing. Please call 613-520-6674 to pay by phone and return the completed form to hcs@carleton.ca.