HEARING SERVICES

CONSENT TO THE RELEASE OF PERSONAL HEALTH INFORMATION BY HEARING SERVICES TO ANOTHER ORGANIZATION/AGENCY

I consent to the personal information of _____ _____,
FIRST NAME LAST NAME

date of birth YYYY/MM/DD, to be disclosed to the following (tick all that apply):

- ☐ Physician _____
- ☐ Health Clinic or Community Health Centre _____
- ☐ Specialist _____
- ☐ The Child Development Centre _____
- ☐ School, Education, Teacher of Deaf & Hard of Hearing _____
- ☐ Social Worker _____
- ☐ First Nations Insured Health Benefits (FNIHB) _____
- ☐ Learning Disabilities Association of Yukon _____
- ☐ Veterans Affairs Canada _____
- ☐ Yukon Hospital Corporation _____
- ☐ Hearing Aid manufacturer _____

Hospital outside of Yukon

- ☐ St. Paul's Hospital _____
- ☐ BC Children's Hospital _____
- ☐ Other _____

- ☐ Other _____
- ☐ Other _____

To be filled out only if Parental/Guardian consent required

I am the parent/guardian of the child listed above. I give consent for the child's information being released.

Name of Parent/Guardian _____ _____ Date YYYY/MM/DD
FIRST NAME LAST NAME

Signature of Parent/Guardian _____

Signature _____ Date YYYY/MM/DD

Note: *This consent remains in effect unless revoked in writing.*

INTERNAL USE ONLY

_____ _____
Signature of Hearing Services Staff Date

Hearing Services
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Whitehorse, Yukon Y1A 4N7
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YG(6530EQ)F1 02/2018

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