HEARING SERVICES

CONSENT TO OBTAIN PERSONAL HEALTH INFORMATION FROM ANOTHER ORGANIZATION/AGENCY

I am requesting the personal health information of _____ _____,
FIRST NAME LAST NAME

date of birth YYYY/MM/DD. I consent to Hearing Services obtaining this information for the purposes of providing health care. I consent to my information being obtained from:

Contact Information
(Please print clearly the contact information of the organizations we are to obtain information from).

_____

_____

_____

_____

_____

_____

To be filled out only if Parental/Guardian consent required

I am the parent/guardian of the child listed above. I give this consent for the child's information to be obtained.

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
204-4114-4th Avenue
Whitehorse, Yukon Y1A 4N7
Phone: 867-667-59132
Fax: 867-667-5922

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