

HEARING SERVICES CONSENT TO OBTAIN PERSONAL HEALTH INFORMATION FROM ANOTHER ORGANIZATION/AGENCY

I am requesting the personal health information of
date of birth <u>YYYY/MM/DD</u> . I consent to Hearing Services obtaining this information for the purposes of provid
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).
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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 Date/MM/DD
FIRST NAME LAST NAME
Signature of Devent/Querdian
Signature of Parent/Guardian

Signature _____

Date YYYY/MM/DD

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

INTERNAL USE ONLY		Hearing Services 204-4114-4th Avenue Whitehorse, Yukon Y1A 4N7
Signature of Hearing Services Staff	Date	Phone: 867-667-59132 Fax: 867-667-5922

Information contained in this form is collected, used and disclosed in accordance with Yukon's *Health Information Privacy and Management Act* and other applicable laws. A written statement of Health and Social Services information practices can viewed at www.hss.gov.yk.ca/healthprivacy.php or by contacting the department's Privacy Officer at healthprivacy@gov.yk.ca.