



## CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION

I, \_\_\_\_\_, hereby authorize the Ottawa Paramedic Service  
(print name)

(City of Ottawa) to disclose the following personal information concerning myself:

To the following individual or organization:

For the purpose of:

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date (dd/mm/yyyy)

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Telephone number

Return this completed Form to:

**Ottawa Paramedic Service  
Professional Standards Section  
2465 Don Reid Drive  
Ottawa, ON K1H 1E2**

or FAX: 613-580-2433

**Please allow 10 business days for processing.  
Documentation must be picked up in person, with official photo identification.  
By appointment only - Monday to Friday, 8:30 am to 4:00 pm**

**Notice with Respect to the Collection of Personal Information  
(Freedom of Information and Protection of Privacy Act)  
(Municipal Freedom of Information and Protection of Privacy Act)  
(Personal Health Information Protection Act),**

This information is collected under the legal authority of the Section 6(8) (C) of the Ambulance Act, R.S.O. 1990, C.A. 19, as amended, for the purpose of administering requests from the public for information concerning the ambulance service. Questions regarding this collection may be addressed to: Professional Standards Section, Ottawa Paramedic Service, 2465 Don Reid Drive, Ottawa, ON K1H 1E2

Date Form received:	ID Verified:	Documentation released:	Patient Signature:	Ottawa Paramedic Service Signature:
ddmmyy	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		