OTTAWA PARAMEDIC SERVICE
SERVICE PARAMÉDIC d'OTTAWA

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

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

Version February 2010

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. 19990, 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 ☐ NO ☐	YES ☐ NO ☐	_____	_____

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