DALHOUSIE UNIVERSITY

STUDENT HEALTH & WELLNESS CENTRE

SHARED RECORDS CONSENT CHANGE FORM

This form will be used to request a change of preference in the sharing of your own personal health records.

1. IDENTIFICATION OF INDIVIDUAL (please print clearly)

Last Name | First Name | Middle initial

Previous surname (if applicable) | Date of birth (YY/MM/DD)

Provincial Health Card Number or Private Insurance Identifier

Mailing address

Daytime telephone number

2. SHARING OF RECORDS

Please indicate your personal health record sharing preference below (mark all that apply):

☐ Parent/guardian ○ yes ○ no if yes, please specify name
_____

☐ Medical history only ○ yes ○ no

☐ Counselling history only ○ yes ○ no

☐ All records ○ yes ○ no

☐ Only with specific provider ○ yes ○ no if yes, please specify name_____

☐ 3rd party (lawyer/insurance company) ○ yes ○ no if yes, please specify

_____

3. SIGNATURE

Relationship to the individual (please check one)

○ *Self* ○ *Substitute Decision Maker* ○ *Other*_____

Records are kept separately for counsellors and physicians. If it becomes necessary for one health provider to share with another, you will be asked to consent to share your information between the counsellor and physician providing care to you and only those involved in your direct care will have access to your records. By filling out this form, you are consenting to the shared records preference indicated on this form. You may change your preference for sharing of your medical or counselling information at any time.

Signature **Date**

Office use only: Date Request Received_____ Date Record Updated_____