

## **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)

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Last Name	First Name	Middle initial
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Previous surname (if applicable)	Date of birth (YY/MM/DD)
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Provincial Health Card Number or Private Insurance Identifier

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Mailing address

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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

\_\_\_\_\_

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

\_\_\_\_\_

### **3. Relationship to the individual** (please check one)

*Self*  *Substitute Decision Maker*  *Other* \_\_\_\_\_

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.

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**Signature**

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**Date**

**Office use only:** Date Request Received \_\_\_\_\_ Date Record Updated \_\_\_\_\_