Sunnybrook
HEALTH SCIENCES CENTRE

Cancer Genetics
Release of Information

PATIENT IDENTIFICATION

PATIENT'S name: (print)_____
(first) (last) (maiden)

Date of birth (YYYY/MM/DD):_____ Date of death (YYYY/MM/DD) (if applicable): _____

Healthcard number (if known):_____

SECTION A: Medical Release

I authorize (name of PATIENT'S hospital/physician): _____ to release my **medical records, pathology reports and/or colonoscopy reports.**

Year(s) of treatment (if applicable): From (YYYY/MM/DD):_____ To (YYYY/MM/DD):_____

SECTION B: Genetic Release

1. I authorize (name of PATIENT'S genetic counsellor/clinic): _____ to release my **genetic test results, family tree (pedigree) and/or genetic consult notes.**

AND

2. I allow the Cancer Genetics and High Risk Program to share my genetic information with:
   - ☐ All interested family members seeking genetic counselling

   OR

   - ☐ The following family members: _____ _____

To release to: Cancer Genetics and High Risk Program, Sunnybrook Odette Cancer Centre
2075 Bayview Avenue, Toronto, ON M4N 3M5
Phone: 416.480.5000 Ext. 85336 Fax: 416.480.5859 Email: occ.genetics@sunnybrook.ca

I understand this information is to be used by the recipient(s) for the purpose(s) of: **Genetic Counselling**

Signature of **PATIENT**/legal representative:_____ Date (YYYY/MM/DD):_____

If legal representative, print name: _____ Relationship to **PATIENT**:_____

Signature of witness:_____ Date (YYYY/MM/DD):_____

Print name of witness:_____

Genetic number and/or name of person having genetic counselling:_____

Notes:

1. This authorization is valid for a period of 90 days from the date of signing and may be rescinded or amended in writing during that period except where action has been taken based on authorization provided;
2. This authorization must contain the *original signature* of:
   a. The patient, parent or legal guardian if the patient is under 14 years of age and unmarried; or the legal representative if the patient is deceased or has been certified mentally incompetent;
   b. The witness to the patient's signature;
3. This authorization shall apply only to information dated prior to date of signature;
4. If the patient does not read or understand English, the authorization form must be interpreted from the patient. The person who acts as the *interpreter must* sign the form as a *witness* to confirm that this has been done.
5. Medical records, pathology reports and/or colonoscopy reports will be collected through the above listed hospital locations and/or through the Sunnybrook Odette Cancer Centre electronic medical files (EMR) and become part of the genetic file.

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PLEASE RETURN A COPY OF THIS AUTHORIZATION FORM WITH THE MEDICAL RECORDS