Children's & Women's Health Centre of BC
DEPARTMENT OF PATHOLOGY & LABORATORY MEDICINE
Division of Laboratory Genetics

CONSENT FOR RELEASE OF INFORMATION

All fields must be completed legibly (patient demographics label acceptable).

Patient Name (Last, First):_____

Date of birth (dd/Mmm/yy): _____

PHN: _____

The Freedom of Information and Protection of Privacy Act of British Columbia prohibits the disclosure of personal information outside of Canada without your explicit consent. Personal information, held by any testing site located outside of Canada, is potentially subject to disclosure demands under the local legal requirements of the country in which the testing site resides.

A test has been ordered by your physician, which will be performed at a testing site outside of Canada.

In order to test the sample and report the results to the ordering physician, the following personal information must be provided with the sample: Patient Name, Date of Birth and Personal Health Number. Brief clinical information relevant to test interpretation may also be provided.

A sample, and the above stated personal information, will be sent to the following testing site:

_____
Laboratory /Institution

_____
Address

I hereby consent to the transfer of a sample and the release of the defined personal information stated above, to the testing site named above, for the purpose of performing testing on the sample.

Person giving consent:

_____ _____
Name (Print) Signature for consent

_____ _____
Relationship to patient Date signed