WINDSOR REGIONAL HOSPITAL
OUTSTANDING CARE – NO EXCEPTIONS!

Consent to Disclose Personal Health Information

(In accordance to the Personal Health Information Protection Act, 2004)

I, _____, authorize_____
(Print your name) *(Print name of your current Hospital/Cancer Program)*

To disclose

☐ Allow the Clinical Trials Navigator from Windsor Regional Hospital to have access to my medical charts (personal health information) for the sole purpose of investigating potential clinical trials options for myself. *

Or

The personal health information of _____
(Name of person for whom you are the substitute decision-maker)

☐ Allow the Clinical Trials Navigator from Windsor Regional Hospital to have access to medical charts of the above named person (personal health information) for the sole purpose of investigating potential clinical trials for the above-named. *

* I realize this process is to aid my treating oncologist and myself in determining what trials, if any, may be appropriate. I also realize there may not be any trials available at this time.

If there is information not to be disclosed to the Clinical Trials Navigator, describe here:

_____

If you have any questions about Clinical Trials and what options may be is right for you, please speak with your treating Oncologist.

By signing below, I understand the purpose for disclosing this personal health information to the Clinical Trials Navigator. I understand that I can refuse to sign this consent form.

My Name: _____

Health Card #: _____ Version Code: _____

Date of Birth: _____ Telephone #:_____

Email (if available): _____

Name of Treating Oncologist:_____

Signature: _____ Date: _____
must be personally signed and dated; e-signatures not permitted

Witness Signature: _____ Date: _____

Fax To: Clinical Trials Navigator, Windsor Regional Cancer Program: Fax: (519) 253- 8102

Canadian Cancer Clinical Trials Network