Risk of using web sites:

The University of Toronto Health & Wellness Centre (the “HWC”) offers patients the opportunity to schedule appointments and view lab results on the web. Transmitting patient information poses several risks of which the patient should be aware. The patient should not agree to use the online service without understanding and accepting these risks. The risks include, but are not limited to, the following:

- The privacy and security of web transmission cannot be fully guaranteed.
- The HWC web site for appointments and linking to your health record is a secured site with 128-bit SSL encryption. The patient agrees to and will comply with the use of encryption software.
- The physician may forward emails internally to the HWC’s staff and to those involved, as necessary, for diagnosis, treatment, reimbursement, health care operations, and other handling. The physician or the HWC will, not however, forward emails externally.
- The physician is not responsible for information lost due to technical failures.

Patient acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form. I consent to the conditions outlined herein, as well as any other instructions that the physician or the HWC may impose to communicate with patients over the web. By signing this document, I understand that I agree to waive any and all claims that I have or may have in the future against the University of Toronto, its board of governors, directors, officers, employees, agents, students and representatives (collectively the “releasees”) and I agree to release the Releasees from any and all liability for any loss, damage or injury that I or my next of kin may suffer, as a result of the improper release of medical information via a website including negligence, breach of contract, or breach of any statutory or other duty of care.

Patient Name: __________________________  Patient Email: __________________________@mail.utoronto.ca
(Must be a utoronto email account)

Date: __________________________  Patient Signature: __________________________
(MM/DD/YYYY)

Date: __________________________  Witness Signature: __________________________
(MM/DD/YYYY)
Patient name: ___________________________     Date: ____________________

(Student No:_________________________)

(please provide us with your emergency contact information. This person is to be contacted ONLY in case of emergency. **PLEASE PRINT**)

1. First Name: ___________________________     Last Name: ___________________________

2. Relationship: ___________________________

3. Telephone Number: (_____ ) ___________________

4. Current Address: ______________________________________________________________

5. City/Province/Postal Code: ______________________________________________________

Family Doctor Information:

Name: __________________________________________________________________________

Address: _________________________________________________________________________

Phone Number: ___________________________
Please fill in the following information about yourself:

<table>
<thead>
<tr>
<th>STUDENT INFORMATION</th>
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<tbody>
<tr>
<td>Last Name</td>
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The University follows an integrated approach to your health and wellness, where the right services are made available according to your needs. These can include medical, counseling, help in crisis and assistance with academic accommodation. The University will hold information about you in confidence and will share this information only with others involved in your health care.

Services you may be involved with might be Health and Wellness Centre, Accessibility Services, Student Crisis Response, Student Academic Progress, Community Safety, University Residences/Housing and your University Registrar.

By signing below, you permit University student support services to share your information to work as a team and provide you with the most complete assistance we can.

Your information will be treated as confidential by our team and will only be shared on a need to know basis.

You do not have to sign to receive services and if you like, you can withdraw your consent at any time by advising us.

- [ ] I wish to limit this authorization to be in effect from _____________ (month, year) to _____________ (month, year)
- [ ] I wish for only certain types of information to be released, specifically:

  __________________________________________________________
  __________________________________________________________

  X ___________________________________________ Date: ________________________________ (MM/DD/YYYY)
  Student Signature

  X ___________________________________________ Date: ________________________________ (MM/DD/YYYY)
  Witness Signature

The University clinicians and counsellors will use information about you only to provide or assist in providing health care to you. The University very rarely may be required to disclose information to authorities in or outside the university, for example if:

1. There is concern that you may harm yourself or someone else or be unable to care for yourself;
2. You reveal apparent, suspected, or potential child abuse or neglect;
3. You report sexual abuse by a Regulated Health Care Professional;
4. Your physician or psychiatrist assesses you to have a medical condition that significantly impairs your ability to operate a motor vehicle.

Please sign below to indicate that you understand the conditions above.

X ___________________________________________ Date: ________________________________ (MM/DD/YYYY)
  Student Signature
Once an appointment is scheduled with Health and Wellness Centre ("HWC"), you will be expected to attend that appointment unless you give the required advance notice. More notice when possible would be appreciated as it helps us ensure we are assisting as many University of Toronto students as possible.

If you are unable to attend any scheduled appointment please call the Health and Wellness Centre at (416) 978-8030 or go to my.healthandwellness.utoronto.ca. You can use your Web Access Account to cancel appointments scheduled 48 hours in advance.

a. Cancellation of a regular 15 minute medical appointment requires at least 4 hours’ notice. Failure to give proper notification will result in a charge of $40 to you.

b. Cancellation of a 30 to 60 minute appointment or workshop requires at least 48 hours’ notice. Failure to give proper notification will result in a charge of $60 to you. **Cancellation of such an appointment booked for a Monday must be cancelled by 4:30PM on Thursday the week before.**

c. Cancellation of a Colposcopy appointment with Dr. Graham requires 72 hours’ notice. Failure to give proper notification will result in a charge of $75 to you.

d. If you have regularly scheduled appointments and do not arrive at one of these appointments, your subsequent appointment times may not be held for you in the following weeks.

e. A hold will be placed on your ROSI account for unpaid invoices from short notice cancellations or a no show visit. This may impact access to your transcripts.

Please sign below to indicate that you have read this agreement, understand it, and agree to the conditions outlined.

Signature: ___________________________ Date: ___________________________ (MM/DD/YYYY)

Thank you for your cooperation.
Please help us manage your ongoing medical care by filling out this form and handing it to your doctor at the beginning of your appointment.

1. Please list any medications you are currently taking with their doses.

__________________________________________________________________________
__________________________________________________________________________

2. Are you allergic to any medications? If yes, please list them with the reaction.

__________________________________________________________________________
__________________________________________________________________________

3. Please list any ongoing or recurring medical problems you have (e.g. asthma, diabetes, hepatitis, high blood pressure, depression, anxiety).

__________________________________________________________________________

4. Please list any significant past medical problems you have had (e.g. surgery, trauma, hospitalization, depression, etc.)

__________________________________________________________________________
__________________________________________________________________________

5. Have you had chicken pox?  Yes / No / Don’t Know

If NO, have you had the Varicella Vaccine? Yes / No / Don’t Know

6. Do you smoke?  Yes / No