

Governing Law and Jurisdiction Agreement for healthcare organizations

This agreement ("Agreement") is entered into by and between _____ and _____ (collectively, the "Parties").
[Name of patient]
[Healthcare organization]

Governing Law

The Parties hereby agree that:

- a) all aspects of the relationship between _____ and _____ (as well as her/his agents, delegates, employees, and any physicians and other independent healthcare practitioners providing medical or other healthcare and treatment to _____, or in association with _____), including without limitation any medical or other healthcare and treatment provided to _____, and
[Name of patient]
[Healthcare organization]

- b) the resolution of any and all disputes arising from or in connection with that relationship, including any disputes arising under or in connection with this Agreement,

shall be governed by and construed in accordance with the laws of the province or territory of _____ (other than conflict of laws rules) and the laws of Canada applicable therein.
[Province or territory]

Exclusive Jurisdiction

The Parties hereby acknowledge that the medical or other healthcare and treatment received by _____ from _____ will be provided in the province or territory of _____, and that the Courts of _____ shall have exclusive jurisdiction to hear any complaint, demand, claim, proceeding or cause of action, whatsoever arising from or in connection with that medical or other healthcare and treatment, or from any other aspect of the relationship between _____ and _____.

Date: _____

Name of patient [Please print]

Date: _____

Per: _____
[Healthcare organization]

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Pembroke Campus
1 College Way
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Tel: 613-732-4700 X 2748
Fax: 613-735-4703



CONSENT TO SHARING OF INFORMATION

I, _____ DATE OF BIRTH _____
FIRST NAME LAST NAME

Hereby authorize any staff/ physician at Algonquin College Health Services to release information regarding my healthcare, including diagnoses or any part of my medical record, to Travel Healthcare Insurance Solutions Inc. / guard.me and its insurers, for the purpose of administering claims.

I understand that this authorization will be valid until such time that consent is withdrawn in writing.

A photocopy, fax or digital copy of this original document shall be considered equally valid.

PATIENT'S SIGNATURE

DATE

WITNESS