Consent for Disclosure and Requesting of Personal Health Information

Based on the Personal Health Information Protection Act, 2004

Health Card #: *(optional)* ______________________________ H#:______________________________

Patient/Client Name ______________________________ Date of Birth ______________

LAST NAME *FIRST NAME* *INITIAL* *(YYYY MM DD)*

Phone Number ______________________________ Email ______________________________

I, ____ hereby authorize

(Patient's Name, Substitute Decision Maker (SDM) or Legal Representative)

Humber River Hospital to DISCLOSE personal health information to:

Name of Third Party Organization: ______________________________

Contact Name: ______________________________ Phone Number: ______________________________

Mailing Address: ______________________________

Insurance/Policy Numbers *(if applicable):* ______________________________

Type of Personal Information or Personal Health Information to be communicate through email: *(specify health information & dates of service)*

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Humber River Hospital to COLLECT personal health information from the following Third Party Organization:

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Phone Number: ______________________________ Fax Number: ______________________________

Please fax requested information back to HRH Unit or Clinic: ______________________________

(List HRH Contact Name, Unit or Clinic)

Phone Number: ______________________________ Fax Number: ______________________________

The Reason for this request is: ______________________________

Signature of Patient, SDM or
Legal Representative: ______________________________ Date: ______________

Relationship to the Patient (if SDM): ______________________________

Signature of Witness: ______________________________ Date: ______________

Print Name of Witness: ______________________________

For witnesses that are not HRH staff - the witness signature needs to be a neutral third party, who does not benefit from signing this legal document. The witness must be of legal age and must be mentally capable in making their own decisions and has known the signer of the document for a long time. The witness must actually see the signer sign the document and verifies that the signer of this legal document is not an imposter.

Notes: 1. This authorization must be dated within the previous 3 calendar months in order for the request to be processed.

2. This authorization may be rescinded or amended in writing during that period except where action has been taken based on authorization provided & shall only apply to information dated prior to date of signature.

3. The authorization must contain:

a) The signature of the patient (capable individual who is 16 years or older to whom the record pertains); or
b) The signature of a person who is authorized by the patient to receive the information on the patient's behalf;
c) The signature of the patient's legal representative if the patient is deceased or has been certified mentally incompetent.
d) The signature of the witness to the patient's or authorized representative's signature.

4. If the person does not read or understand English, the authorization form must be interpreted for the patient. The person who acts as the *interpreter must* sign the form as a *witness* to confirm that this has been done.

5. Health Records will only be disclosed up to the date of signature.