Authorization for Release of Personal Health Information

Based on the *Personal Health Information Protection Act, 2004*

1235 Wilson Avenue, Toronto, ON M3M 0B2
Phone: 416-242-1000 ext. 82300
Fax: 416-242-1085
E-mail: privacy@hrh.ca

Health Card # *(optional)*: _____ Medical Record Number: _____

Patient Name: _____ Date of Birth: _____
LAST NAME *FIRST NAME* *(DD/MM/YYYY)*

Address: _____
STREET ADDRESS *CITY* *PROVINCE* *POSTAL CODE*

Phone Number: _____ E-mail: _____

I, _____ hereby authorize
(PATIENT'S NAME, SUBSTITUTE DECISION MAKER (SDM) OR LEGAL REPRESENTATIVE)

Humber River Hospital to ☐ **release to:** ☐ **collect from:**

Name of Recipient/Health Care Institution/Health Care Provider: _____

Contact Name: _____ Department: _____

Address: _____
STREET ADDRESS *CITY* *PROVINCE* *POSTAL CODE*

Phone Number: _____ Fax Number: _____

Personal Health Information related to the following treatment or admission *(specify health information & dates of service)*:

_____

_____

If COLLECTING from, please fax requested information back to:

HRH Unit or Clinic: _____ Contact Name: _____

Phone Number: _____ Fax Number: _____

Signature of Patient, SDM or Legal Representative: _____ Date: _____
(DD/MM/YYYY)

Relationship to Patient (if SDM): _____

Signature of Witness: _____ Date: _____
(DD/MM/YYYY)

Print Name of Witness: _____

For witnesses that are not HRH staff: The witness signature must be a neutral third party, who does not benefit from signing this legal document. The witness must be capable individual who is 16 years or older and must be present and actually see the patient, SDM or legal representative sign the document.

Notes:

1. This authorization is valid for a period of **90 days from the date of signing**.
2. Personal health information will only be disclosed up to the date of signing.
3. A new *Authorization to Release Personal Health Information* form will need to be completed for any information requested beyond this date.
4. This authorization may be rescinded or amended in writing during that period except where action has been taken based on authorization provided & shall only apply to information dated prior to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.
5. 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.
6. 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.