Authorization for Release/Collection of Personal Health Information

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

Health Information Services
1235 Wilson Avenue, Toronto, ON M3M 0B2
(P) 416-242-1000 ext. 82300 (F) 416-242-1085
E-mail: roi@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*

Contact Phone Number: _____ E-mail: _____

I, _____, hereby authorize **Humber River Hospital** to
(NAME OF PATIENT/SUBSTITUTE DECISION MAKER (SDM))

☐ **RELEASE personal health information to:** ☐ **COLLECT personal health information from** *(INTERNAL USE ONLY)*:

Name of Person, Agency and/or Institution: _____

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

Contact Phone Number: _____ Fax Number or E-mail: _____

If COLLECTING, please send requested information back to:

HRH Unit or Clinic: _____ Contact Name: _____

Phone Number: _____ Fax Number: _____

Please indicate which personal health information (with specific admission/visit date(s)) you are authorizing Humber River Hospital to release or collect, as noted above:

_____

_____

This information will be used for the purpose(s) of *(SELECT AS MANY THAT APPLY)*:

☐ Further Medical Treatment ☐ Coordination of Services ☐ Litigation ☐ Insurance Claim ☐ Estate Settlement
☐ Other: _____

Prior to signing, I understand:

- That this authorization must be signed by the patient or by the legally authorized representative in the case that the patient is deceased/deemed incapable by a medical professional.
- That typed signatures are not accepted.
- The private and confidential nature of this information and agree that it will be used only for the stated purpose(s).
- That this authorization is valid for a period of 90 days from the date of signature unless specified otherwise.
- That personal health information will only be disclosed up to the date of signature.
- That a new ***Authorization for Release/Collection of Personal Health Information*** form will need to be completed for any information requested beyond this date.
- That I may withdraw my consent in writing at any time, but this directive will not be applied retroactively.
- That the witness must be a capable individual who is 16 years or older, a neutral third party who does not benefit from signing this legal document, and someone who physically sees the patient, SDM or legal representative sign.
- That if I am unable to have a witness sign this document, I will include a scanned copy of photo ID with this consent form.

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

Relationship to Patient *(ONLY IF PATIENT DECEASED/DEEMED INCAPABLE OF SIGNING)*: _____

Signature of Witness: _____ Print Name of Witness: _____

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