

CONSENT TO ACCESS / DISCLOSE PERSONAL HEALTH INFORMATION

I hereby authorize Hôtel-Dieu Grace Healthcare to disclose Personal Health Information record(s) of:

Patient/Client's **Last** Name (Print) Patient/Client's **First** Name (Print) Middle Initial(s)

Date of Birth (i.e: July 1, 1950) Telephone Number

Mailing Address (including City, Province, Postal Code)

To: _____ for purpose of:
(Name of Person / Agency requesting information)

- Personal Use Legal /Lawyer Insurance
 Other (please specify) _____

I wish to obtain/disclose the following record(s):

Please specify report(s): _____

For the specific visit: _____ or Visit(s) from: _____ to _____
(Enter date i.e: July 1, 1950) (Enter dates i.e: July 1, 1950)

NOTE: In accordance with PHIPA (Personal Health Information Protection Act) authorization must be signed by the patient/client and **if incapable by the Parent/Guardian or Substitute Decision Maker/Executor**. A substitute decision maker is a person authorized by PHIPA to consent on behalf of an individual, to disclose personal health information about the individual.

If you are the Parent/Guardian/Substitute Decision-Maker/Executor, please provide your contact information: (Copies of documentation that provide your authority as a Substitute Decision-Maker must be provided)

- Copy of Will Power of Attorney Documents Notarized Letter Parent/Guardian

Last Name (Print) First Name (Print) Middle Initial(s)

Date of Birth (i.e: July 1, 1950) Relationship to Patient/Client Telephone Number

If different than above mailing address (including City, Province, Postal Code)

Signature: _____
Patient/Client/(Child if applicable)/Parent/Guardian/Substitute Decision-Maker/Executor **Date:** (i.e: July 1, 1950)

This Consent for Disclosure is valid for 12 months. It pertains to the disclosure of information that is specific to treatment received on or before the date signed. It can be altered or withdrawn at any time by written notification to the Health Information Management Department. Withdrawal of consent is not retroactive to information already disclosed.



CONSENT TO ACCESS / DISCLOSE PERSONAL HEALTH INFORMATION

Office Use Only

Verification of identity of individual consenting to the disclosure:

Form of ID: Driver's License Passport Notarized letter/Lawyer's letter Birth Certificate
 Other (specify): _____

ID Checked by:

Print Name

Signature

Person Identified/Authorized for Pick-Up:

Print Name

Relationship to Individual Consenting

Telephone Number

Invoice Issued: N/A

Date (MM/DD/YYYY)

Signature

Amount Owing: \$ _____

Signature of Person Authorized for Pick-Up

Date (MM/DD/YYYY)

Form of ID: Driver's License Passport Notarized letter/Lawyer's letter
 Other (specify): _____

ID Checked by:

Print Name

Signature