Office Use
MRN:

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:______________________________
(Name of Person / Agency requesting information)

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 It can be altered or withdrawn at any time by written notification to the Health Information Management Department.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.

HÔTEL-DIEU GRACE HEALTHCARE
ESTD 1888

Office Use
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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