Trillium Health Partners

MRN: _____

www.trilliumhealthpartners.ca

CONSENT TO DISCLOSE, TRANSMIT, ACCESS OR EXAMINE PERSONAL HEALTH INFORMATION
PURSUANT TO THE PERSONAL HEALTH INFORMATION PROTECTION ACT, 2004 (PHIPA)

Records to be accessed:

Patient: _____

Date of Birth (DD/MM/YY):_____/_____/_____

Health Card Number: _____

Phone Number: (_____) _____

Address: _____

_____

Recipient of Records:

☐ Patient **OR**

Name: _____

Phone Number :(_____) _____

Fax Number :(_____) _____

Address: _____

_____

Records to be disclosed:

Dates of Visit: _____

☐ Mississauga Hospital ☐ Queensway Health Centre
☐ Credit Valley Hospital

☐ Emergency Visit
☐ Dictated Notes (Operative Report, Discharge Summary, etc.) ☐ Visit History ☐ DI/SCM CD

☐ Other_____

Reason for Request and Release of Information:

I, _____ hereby authorize
(Patient or SDM)
Trillium Health Partners to disclose the aforementioned health information to the recipient indicated for the purpose listed.

☐ Personal ☐ Legal ☐ Insurance

☐Other (specify):_____

_____

_____ _____ _____
Signature of Patient or Substitute Decision Maker | Signature of Witness | Date (DD/MM/YYYY)

If the person signing is not the patient, please state the relationship and authority to do so.

_____ _____
Relationship to Patient | Authority (i.e.: Power of Attorney, Next of Kin, etc...)

Interpreter: I have done my best to accurately translate this form for the person referred above, and will not divulge any information learned during this review.

Interpreter Name: _____ Interpreter Signature: _____

*Note: (SDM) a substitute decision-maker is a person authorized under PHIPA to consent, on behalf of an individual, to disclose personal health information about the individual.
This Consent for Access to Disclosure will be valid for a three month period as of the date of the signature unless otherwise specified. This authorization may be withdrawn at any time by written notification to the hospital, but is not retroactive to information released before consent is withdrawn.