

# How to Complete the Consent to Disclose, Transmit, Access or Examine Personal Health Information Form

To request a copy of your Personal Health Information, you must provide the following:

A completed Consent to Disclose, Transmit, Access or Examine Personal Health Information form.

Please ensure that the consent form needs to be signed, dated within 90 days and witnessed.

- · Administrative Fee (Please see our THP Website for more details)
- · One piece of government issued photo ID for the requester in order to validate signature/ identity

We are required to respond within 30 days once all requirements are met for the request. The Release of Information office will contact you when the records are ready to be released/ picked up.

#### Section 1: Records to be Accessed

Complete this section with the patient's information.

#### Section 2: Recipient of Records

If you are receiving your own Personal Health Information, check 'Patient'.

If you are releasing your information to another individual (such as your parent, physician, lawyer etc.), their information must be completed in this section.

# Section 3: Records to be Disclosed

Provide the date(s) of visit(s) and check off which records you are looking to obtain. If what you are looking for is not listed in the options provided; check off "Other" and list in detail what you are specifically looking for.

If you do not know the exact date(s) of the records you are requesting, provide your best estimate.

# **Section 4: Purpose**

Please check the purpose of the usage of the Personal Health Information. The Personal Health Information should only be used for the purpose indicated.

# Section 5: Signatures

If you are the patient requesting your own records and are 12 years of age or older, you must sign and date this section.

# Children under the age of 12:

· The custodial parent must print their name and sign the form

#### Substitute Decision Maker (SDM):

- If you are the SDM, you must print your name and sign this section and provide the Power of Attorney of Personal Care Document. This is only acceptable if the patient is incapable of signing for themselves and are alive.
- If you are making a request for records of a deceased patient, the executor's information must be completed in this section. The executor will be asked to provide a copy of the will. If no will exists, a Certificate of Appointment of Estate Trustee will be required.

\*NOTE: Only <u>HAND-WRITTEN</u> signatures are accepted at this time; E-SIGNATURES are not permitted

# Section 6: Interpreter (if applicable)

The Interpreter should print their name and sign the form.

Requests can be mailed, emailed or faxed to the Health Information Management department at the below addresses and fax numbers.

# Email:

releaseofinformation@thp.ca

#### Mississauga Hospital:

100 Queensway West, Mississauga ON L5B 1B8 Phone: 905-848-7181 Option 8 Fax: 905-848-7677

#### Credit Valley Hospital:

2200 Eglinton Avenue West, Mississauga ON L5M 2N1 Phone: 905-813-1100 Ext. 5885 Fax: 905-813-4101

	Trillium Health Partners			CSN Number:			
				Release ID Number:			
				ERSONAL HEALTH IN			
SECTION 1 - Records to be Accessed			SECTION 2	SECTION 2 - Recipient of Records			
Patient Name:			Patient OR	☐ Patient OR Name of Recipient of Records:			
Date of Birth (DD/MM/YY):			Traine or resp.	Name of Neuplett of Necords.			
Health Card Number:			Phone Number	Phone Number:			
Phone Number:							
Address:			Address:	Fax Number:			
			7.00.000				
SECTION 3 - Records	s to be Disclosed		SECTION 4	- Purpose			
Visit Dates(DD/MM/YYYY):			I understand that this personal health information is to be used only by the recipient for the purposes of:				
☐ Visit List	Operative Re		Personal	□ Legal □ Insurance			
☐ Emergency Visit ☐ Diagnostic Imaging Repo	Nursing Note		Other (speci				
☐ Lab		•	[]				
Notes (Consultations, Discharge Summary)	☐ Imaging CD						
Other:			H				
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Patient (12 years and older) Signature:  Custodial Parent/Guardian Name:				Date(DD/MM/	YY):		
	Deleties to I						
SDM Name:*	Relation to i	Patient:	Signature:	Date(DD/MM/			
	Relation to i	Patient:	Signature:	Date(DD/MM/			
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MRN Number:	
CSN Number:	
Release ID Number:	

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

SECTION 1 - Record	ds to be Accessed		SECTION 2 -	Recipient of Records				
Patient Name:			Patient OR					
	):		Name of Recipier	nt of Records:				
			Phone Number					
Phone Number:								
Address:			Address:					
SECTION 3 - Record	ds to be Disclosed	_	SECTION 4 -	Purpose				
Visit Dates(DD/MM/YYYY	):			t this personal health information is to be used only for the purposes of:				
Visit List Emergency Visit Diagnostic Imaging Rep Lab	Operative Report Nursing Notes ports Birth Records	t	Personal Other (specify	Legal Insurance				
Notes (Consultations, Discharge Summary)								
SECTION 5 - Signatures								
Patient (12 years and olde	r) Signature:			Date(DD/MM/YY):				
	Name:							
				Date(DD/MM/YY):				
Witness Name:								
Witness Name: Signature: Date(DD/MM/YY): *Note: (SDM) a substitute decision-maker is a person authorized under the Personal Health Information Protection Act to consent, on behalf of an individual, to disclose personal health information about the individual.  SECTION 6 - Interpreter								
As the interpreter, I have during this review.	lone my best to accurately tran	slate this form for th	e person referred a	bove, and will not divulge any information learned				
_		Interpreter Signatur	e:	Date(DD/MM/YY):				
SECTION 7 - Authorization Information								
time by written notification be disclosed for visits up to held for a maximum of 90 collected on this form will I	to the hospital, but is not retro- to the date of signing. We are re days from when you are notified be used to facilitate the access	active to information equired to respond ved of completion. If the request process, in	released before co vithin 30 days upon ney are re-requested form program evalu	signature. This authorization may be withdrawn at any onsent is withdrawn. Personal health information will only the receipt of the complete request. Records will be d, appropriate fees will be applied. Information lation and training in accordance with PHIPA. Should THP at any site mentioned at the bottom of the form.				
Hospital Use Only								
•	ndividual consenting to access/		Health Card	Other				
Requestor: Form of ID:	Driver's License	Passport	neallii Calu	Other:				
Recipient: Form of ID:	Driver's License	Passport	Health Card	Other:				
Validation of SDM:	Power of Attorney	Will	Other:					
ID Checked by: Name:								

Requests can be mailed, faxed or emailed to the Health Information Management department at the below address.

Email: releaseofinformation@thp.ca

Mississauga Hospital:100 Queensway West, Mississauga Ontario, L5B 1B8Phone: 905-848-7181, option 8Fax: 905-848-7677Credit Valley Hospital:2200 Eglinton Avenue West, Mississauga Ontario, L5M 2N1Phone: 905-813-1100, extension 5885Fax: 905-813-4101