Trillium Health Partners

MRN: ____________________________
Account #: ________________________
Request #: ________________________

CONSENT TO DISCLOSE, TRANSMIT, ACCESS OR EXAMINE PERSONAL HEALTH INFORMATION

PURSUANT TO THE PERSONAL HEALTH INFORMATION PROTECTION ACT, 2004 (PHIPA)

Section 1

Records to be accessed:

Patient: ____
Date of Birth (DD/MM/YY): _______ /_______ /_______
Health Card Number: ___________________________________
Phone Number: (________) _____________________________
Address: ____
____

Section 2

Recipient of Records: ☐ Patient **OR**

Name: ____
Phone Number: (_____) _________________________________
Fax Number: (_____) ___________________________________
Address: ____
____

Section 3

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: ______________________________________

Section 4

Purpose: I understand that this personal health information is to be used only by the recipient for the purposes of:

☐ Personal ☐ Legal ☐ Insurance

☐ Other (specify): _____________________________________
____

Section 5 **Signatures:**

☐ I am the patient (12 years and older): ____ Date: _________________
☐ I am the custodial parent/guardian: ___________________________ Relation to Patient: ___________________ Date: _________________
☐ I am SDM*: ____ Relation to Patient: ___________________ Date: _________________
☐ I am the Recipient of the Records: ___________________________ Relation to Patient: ___________________ Date: _________________

*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.

Section 6

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: _____________________________ Date: _______________

Section 7

This Consent for Access to Disclosure will be valid for a three month period as of the date of the signature. This authorization may be withdrawn at any time by written notification to the hospital, but is not retroactive to information released before consent is withdrawn. Personal health information will only be disclosed for visits up to the date of signing. We are required to respond within 30 days upon the receipt of the complete request. Records will be held for a maximum of 90 days from when you are notified of completion. If they are re-requested, appropriate fees will be applied. Information collected on this form will be used to facilitate the access request process, inform program evaluation and training in accordance with PHIPA. Should you have questions regarding the information collection practices or processes, please contact THP at any site mentioned at the bottom of the form.

HOSPITAL USE ONLY:

Verification of identity of individual consenting to access/ disclosure:
Requestor: Form of ID: ☐ Driver's License ☐ Passport ☐ Health Card ☐ Other: _________________________________
Recipient: Form of ID: ☐ Driver's License ☐ Passport ☐ Health Card ☐ Other: _________________________________
Validation of SDM: ☐ POA ☐ Will ☐ Certificate of Appointment of Estate Trustee with/without will
ID Checked by: Name: ____
Fee: $ 30.00 (Non-refundable Basic Search Fee) + $0.25 per page after 20.

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

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