

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 and signed Consent to Disclose, Transmit, Access or Examine Personal Health Information form
- One piece of government issued photo ID of requestor and recipient
- Administrative Fee (See [page](#) for details)

We are required to respond within 30 days upon the receipt of the complete request. Release of Information office will contact you when the records are ready for pick up, and inform you of the balance owing (if applicable). One piece of government issued photo ID will be required for identity verification before the records are released.

Section 1: Records to be accessed:

Complete this section with all patient 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, etc.), their information must be completed.

Section 3: Records to be disclosed:

List, in detail, the records you are requesting and the dates pertaining to the visit. Please specify the site(s). 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. The requestor needs to provide supporting documents for verification.

Children under the age of 12:

- The custodial parent must print their name and sign the form
- In the event that one parent has sole custody, proof of custody must be provided

Substitute Decision Maker (SDM):

- If you are the Power of Attorney, you must print your name and sign in this section and show the original Power of Attorney
- If you are making a request for records of a deceased patient, the executor's information must be completed in this section. The executor should show the original will. If no will exists, a Certificate of Appointment of Estate Trustee is required.

Section 6: If applicable

The Interpreter should print their name and sign the form.

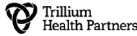
Requests can be mailed or faxed to the Health Information Management department at the below address.

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

		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: <input type="checkbox"/> Patient OR Name: _____ Phone Number: (____) _____ Fax Number: (____) _____ Address: _____	
Section 3 Records to be disclosed: Dates of Visit: _____ <input type="checkbox"/> Mississauga Hospital <input type="checkbox"/> Queensway Health Centre <input type="checkbox"/> Credit Valley Hospital <input type="checkbox"/> Emergency Visit <input type="checkbox"/> Dictated Notes (Operative Report, Discharge Summary, etc.) <input type="checkbox"/> Visit History <input type="checkbox"/> Other: _____ <input type="checkbox"/> DI/SCM CD	Section 4 Purpose: I understand that this personal health information is to be used only by the recipient for the purposes of: <input type="checkbox"/> Personal <input type="checkbox"/> Legal <input type="checkbox"/> Insurance <input type="checkbox"/> Other (specify): _____	
Section 5 Signatures: <input type="checkbox"/> I am the patient (12 years and older): _____ Date: _____ <input type="checkbox"/> I am the custodial parent/guardian: _____ Relation to Patient: _____ Date: _____ <input type="checkbox"/> I am SDM*: _____ Relation to Patient: _____ Date: _____ <input type="checkbox"/> I am the Recipient of the Records: _____ Relation to Patient: _____ Date: _____ <small>*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.</small>		
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 <small>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.</small>		
HOSPITAL USE ONLY: Verification of identity of individual consenting to access/ disclosure: Requestor: Form of ID: <input type="checkbox"/> Driver's License <input type="checkbox"/> Passport <input type="checkbox"/> Health Card <input type="checkbox"/> Other: _____ Recipient: Form of ID: <input type="checkbox"/> Driver's License <input type="checkbox"/> Passport <input type="checkbox"/> Health Card <input type="checkbox"/> Other: _____ Validation of SDM: <input type="checkbox"/> POA <input type="checkbox"/> Will <input type="checkbox"/> 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.		
<small>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</small>		
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