Trillium Health Partners
Better Together

Mississauga Hospital
100 Queensway West
Mississauga ON L5B 1B8
T: (905) 848-7100
www.trilliumhealthpartners.ca

HOW TO REQUEST YOUR COVID-19 LAB REPORT

1

COMPLETE THE CONSENT TO DISCLOSE PHI FORM

Complete and sign sections 1 to 5 of the Consent to Disclose Personal Health Information (PHI) form.

Sign with your valid signature (found on your ID).

2

COMPLETE THE CONSENT FOR EMAIL FORM

Complete and sign the Consent for Email Communication form. Include the date and your email address.

Sign with your valid signature (found on your ID).

3

ATTACH PATIENT ID

Only use valid government issued IDs (health card, driver's license, passport).

Signature on IDs must match the signatures on the forms.

4

EMAIL FORMS AND ID

Attach both forms and a copy of your ID (photos or scanned PDF) to an email.

Send email to ReleaseOfInformation@thp.ca.

Please complete all four steps to prevent delays.

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

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PATIENT CONSENT FOR EMAIL COMMUNICATION –Release of Information

I, _____ (*name of Patient/Substitute Decision Maker*) wish to receive records from the hospital through email. I understand that these email messages are encrypted on the hospital email system. However, the hospital cannot guarantee the security of messages that I receive and send from my health care provider. Email is convenient but there is also a risk that information exchanged can be disclosed to a third party. It can be intercepted, forwarded, stored, even changed, or accessed by third party or email providers without anyone's knowledge or consent. This also applies to the use of email.

I agree not to use email to communicate emergency or urgent health matters since email messages can be delayed for technical reasons. I understand that my care provider may make decisions about my treatment based on information I provide and that this information will also form part of my health record if it is relevant to my care.

I acknowledge that at any time, I or the hospital can decide that we no longer wish to communicate through email. If I decide to stop communicating through email, I agree to inform the hospital at the earliest opportunity. If the hospital cannot continue email communication with me, the hospital will notify me at the earliest opportunity.

By signing this Consent, I confirm I have read and agree to these terms.

Date Signed (YYYY MM DD)	**Email Address**
Name of Patient/Substitute Decision Maker	**Signature of Patient/Substitute Decision Maker**
Name of Translator (if required)	**Signature of Translator (if required)**

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