Trillium Health Partners

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 - Records to be Accessed

Patient Name: _____

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

Health Card Number: _____

Phone Number: _____

Address:

_____

SECTION 2 - Recipient of Records

☐ Patient **OR**

Name of Recipient of Records:

_____

Fax Number: _____

Phone Number: _____

Address:

_____

SECTION 3 - Records to be Disclosed

Visit Dates(MM/DD/YYYY): _____

☐ Visit History
☐ Emergency Visit
☐ Diagnostic Imaging Reports
☐ Lab
☐ Notes (Consultations, Discharge Summary)
☐ Operative Report
☐ Nursing Notes
☐ Imaging CD
☐ Birth Records

☐ 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

☐ Patient (12 years and older): _____ Date(dd/mm/yy): _____

☐ Custodial parent/guardian: _____ Relation to Patient: _____ Date(dd/mm/yy): _____

☐ SDM:* _____ Relation to Patient: _____ Date(dd/mm/yy): _____

☐ Witness Signature: _____ Relation to Patient: _____ 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 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(dd/mm/yy): _____

SECTION 7 - Authorization Information

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 This authorization may be withdrawn at any time by written notification to the hospital, but is not retroactive to information released before consent is withdrawn.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.

Fees: $30.00 (Non-refundable Basic Search Fee) + $0.25 per page after 20 pages

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: ☐ Power Of Attorney ☐ Will ☐ Certificate of Appointment of Estate Trustee with/without will

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 1B8 Phone: 905-848-7181, option 8 Fax: 905-848-7677

Credit Valley Hospital: 2200 Eglinton Avenue West, Mississauga Ontario, L5M 2N1 Phone: 905-813-1100, extension 5885 Fax: 905-813-4101