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: Method of Delivery

Indicate how you would like to receive the requested records.

Section 6: 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

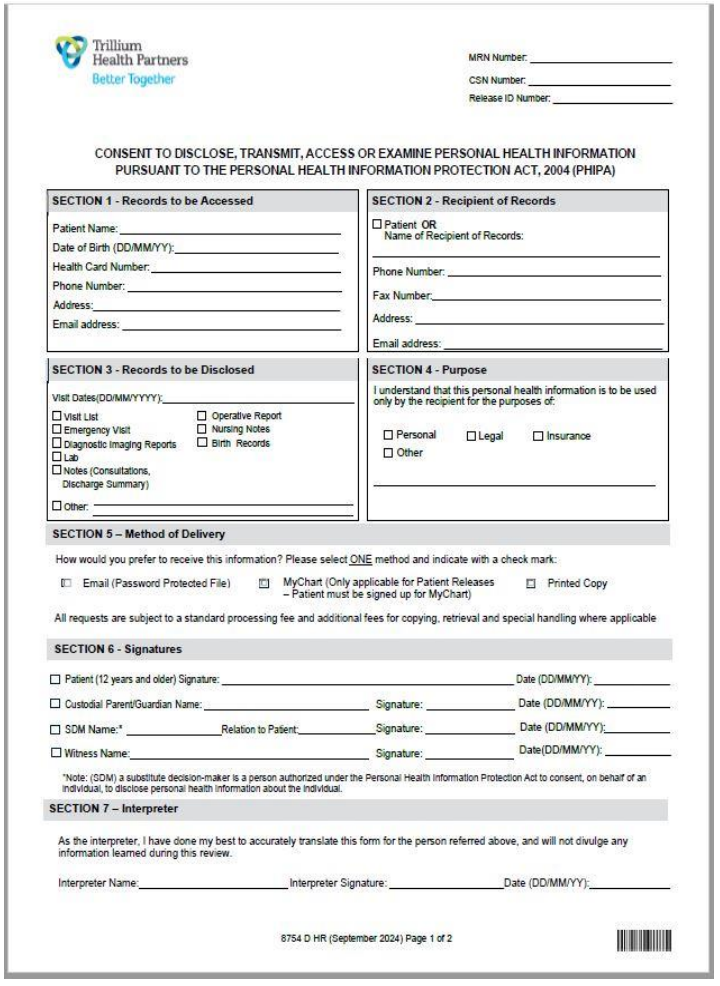
Substitute Decision Maker (SDM):
- If you are the SDM, you must print your name and sign this section and provide the **Power of Attorney of Personal Care** Document. This is only acceptable if the patient is incapable of signing for themselves and are alive.
- If you are making a request for records 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, either a Certificate of Appointment of Estate Trustee (without a Will) OR a Notarized letter (signed by Notary Public) Indicating the patient did not have a Will at the time of death and the applicant is the next of kin/Personal Representative of the patient will be requested.

  ***NOTE: Only HAND-WRITTEN signatures are accepted at this time; E-SIGNATURES are not permitted**

Section 7: 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.



Trillium Health Partners
Better Together

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: _____
Email address: _____

SECTION 2 - Recipient of Records

☐ Patient OR
Name of Recipient of Records: _____
Phone Number: _____
Fax Number: _____
Address: _____
Email address: _____

SECTION 3 - Records to be Disclosed

Visit Dates(DD/MM/YYYY): _____

☐ Visit List
☐ Emergency Visit
☐ Diagnostic Imaging Reports
☐ Lab
☐ Notes (Consultations, Discharge Summary)
☐ Operative Report
☐ Nursing Notes
☐ 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 _____

SECTION 5 – Method of Delivery

How would you prefer to receive this information? Please select ONE method and indicate with a check mark:

☐ Email (Password Protected File) ☐ MyChart (Only applicable for Patient Releases – Patient must be signed up for MyChart) ☐ Printed Copy

All requests are subject to a standard processing fee and additional fees for copying, retrieval and special handling where applicable

SECTION 6 - Signatures

☐ Patient (12 years and older) Signature: _____ Date (DD/MM/YY): _____
☐ Custodial Parent/Guardian Name: _____ Signature: _____ Date (DD/MM/YY): _____
☐ SDM Name:* _____ Relation to Patient: _____ Signature: _____ Date (DD/MM/YY): _____
☐ 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 7 – 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): _____

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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
Better Together

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: _____

Email address: _____

SECTION 2 - Recipient of Records

☐ Patient **OR**
Name of Recipient of Records:

_____

Phone Number: _____

Fax Number: _____

Address: _____

Email address: _____

SECTION 3 - Records to be Disclosed

Visit Dates(DD/MM/YYYY): _____

☐ Visit List
☐ Emergency Visit
☐ Diagnostic Imaging Reports
☐ Lab
☐ Notes (Consultations, Discharge Summary)
☐ Operative Report
☐ Nursing Notes
☐ 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

_____

SECTION 5 – Method of Delivery

How would you prefer to receive this information? Please select ONE method and indicate with a check mark:

☐ Email (Password Protected File) ☐ MyChart (Only applicable for Patient Releases – Patient must be signed up for MyChart) ☐ Printed Copy

All requests are subject to a standard processing fee and additional fees for copying, retrieval and special handling where applicable, including if there are multiple delivery methods selected.

SECTION 6 - Signatures

☐ Patient (12 years and older) Signature: _____ Date (DD/MM/YY): _____

☐ Custodial Parent/Guardian Name: _____ Signature: _____ Date (DD/MM/YY): _____

☐ SDM Name:* _____ Relation to Patient: _____ Signature: _____ Date (DD/MM/YY): _____

☐ 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 7 – 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): _____

Trillium Health Partners
Better Together

MRN Number: _____

CSN Number: _____

Release ID Number: _____

SECTION 8 - 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.

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 ☐ Other: _____

ID Checked by: Name: _____

Requests can be mailed, faxed or emailed to the Health Records 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 Extn 5885 Fax: 905-813-4101

Hours of Operation: Monday to Friday between 8:00am – 4:00pm