Trillium Health Partners

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. 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.

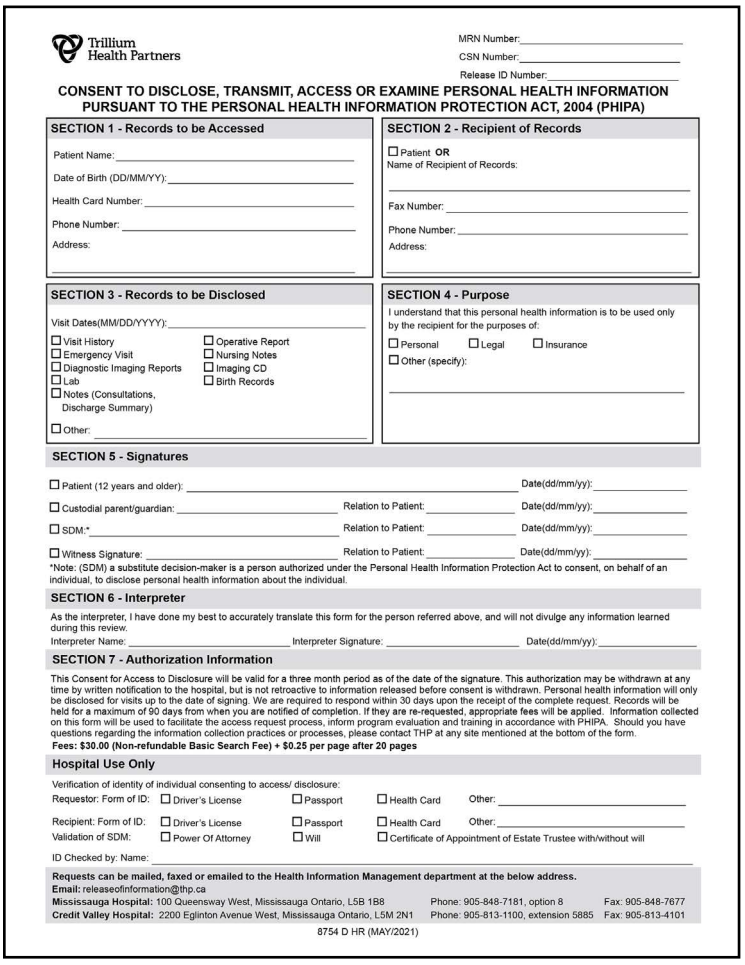
Section 6: If applicable
The Interpreter should print their name and sign the form.

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

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

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

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Email: releaseofinformation@thp.ca
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Credit Valley Hospital: 2200 Eglinton Avenue West, Mississauga Ontario, L5M 2N1 Phone: 905-813-1100, extension 5885 Fax: 905-813-4101

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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): _____

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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: _____

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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)