PROVIDENCE Healthcare

CONSENT FOR ACCESS and/or DISCLOSURE OF PERSONAL HEALTH INFORMATION

Pursuant to the Personal Health Information Protection Act, 2004 (PHIPA)

PATIENT/RESIDENT/CLIENT INFORMATION		
Last Name	First Name	Middle Name
Street Address (No. and Name)		Apt. No.
City	Province/State	Postal Code/ZIP
Phone No.	Date of Birth (DD/MM/YYYY)	OHIP No.

REASON FOR REQUEST

Personal health information to be disclosed (Please select one): ❑ Review only ❑ Requesting copies

I understand that this personal health information is to be used only by the recipient for the purposes of:

❑Patient/Resident/Client/SDM/Executor own access

❑Health Care Provider for continuation of care

❑Other (Specify)_____

❑Insurance

❑Lawyer

REQUESTOR INFORMATION

❑ Patient/Resident/Client (Self)

❑ Substitute Decision Maker for Personal Care (Please provide *Power of Attorney for Personal Care* document)

❑ Executor (please provide Will document)

❑ Health Care Provider

❑ Third Party

Company Name (if applicable)		
Last Name	First Name	Middle Name
Street Address (No. and Name)		Apt. No.
City	Province/State	Postal Code/ZIP
Phone No.	Fax No.	

PERSONAL HEALTH INFORMATION AUTHORIZED FOR RELEASE

Description of personal health information and dates (if known) to be disclosed:

❑ Complete Health Record (date of admission and discharge) _____

❑ Admission Note (date if known) _____

❑ Final Note (date if known) _____

❑ Lab and Test Results (Specify) _____

❑ Consultation Note(s) (Specify) _____

❑ Other (Specify) _____

_____

Personal Health Information Disclosed To:

❑ I understand that Providence Healthcare cannot be held responsible for any subsequent collection, use, disclosure, loss or misuse of the personal health information that has been released to me.

REQUESTOR SIGNATURE(s)		
Requestor Name (Print)	Requestor Signature	Date (DD/MM/YYYY)
Requestor Name (Print)	Requestor Signature	Date (DD/MM/YYYY)
Witness Name (Print)	Witness Signature	Date (DD/MM/YYYY)

NOTES:

- Please **fax** your completed consent form to the Health Information Management department at **416-285-3635** or **mail** to:

  Providence Healthcare
  Health Information Management
  3276 St. Clair Avenue East
  Toronto ON M1L 1W1

- If you have any questions **call** us at **416-285-3666 x 4336**
- This authorization is valid for a period of **90 days** from the date of signing.
- This consent for release of patient information **may be withdrawn** in writing at any time.
- Processing time is dependent on the volume of information requested and is approximately **1 - 30 business days**.
- **Fee** for requesting **copies** (except for continuation of care): $**30.00** (includes first 20 pages) and **$0.25 per additional page,** plus **HST**.
- Other charges may apply as per Providence Healthcare policy.

FOR INTERNAL USE ONLY – RESPONSE TO REQUEST	
Date Request Received (DD/MM/YYYY)	Date Response Issued (DD/MM/YYYY)
Response to Request: ❑ Request granted ❑ Request not granted ❑ Request granted in part If complete access request was not granted, reason for refusing the request/part of the request:	
Type of disclosure provided: ❑Review only ❑Copies Only ❑Fax to Health Care Provider	
Date of Extension – if required _____ (DD/MM/YYYY) Date Requestor Notified _____ (DD/MM/YYYY) Reason for Extension:	
Requestor's photo ID verified by (initials)_____	Fee Quoted $ _____
Request Processed by: Name (print) Signature Title	