AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION

Pursuant to the *Personal Health Information Protection Act, 2004*

Patient Name: _____ **Date of Birth (MM/DD/YYYY):** _____

Patient Address: _____
Street City Province Postal Code

Telephone (Daytime): _____ **Email:** _____ **OHIP No.:** _____

Nature of Personal Health Information to be Disclosed:

☐ All Medical Records

☐ Selection of Medical Records from _____ to _____
Date (MM/DD/YYYY) Date (MM/DD/YYYY)

Please provide details regarding the selection of records requested (*e.g.*, clinic name, unit admitted to, medical imaging only).

_____

To Whom Will The Requested Records Be Disclosed:

☐ Self ☐ Lawyer ☐ Insurance Co. ☐ Care Provider ☐ Other: _____
Name

Record Format ☐ Paper

Delivery Method: ☐ In Person

Contact Information for Individual Receiving Records

Name ("Requestor"): _____

Address: _____
Street City Province Postal Code

Telephone (Daytime): _____

Email: _____

Fax: _____

Authorization

In accordance with PHIPA, authorization for BCHS to disclose a BCHS' patient's personal health information must be signed by the Patient and if the Patient is not capable, the person with legal authority to authorize BCHS to release personal health information. If the person authorizing the disclosure is not the Patient, please state your relationship to the Patient and provide a copy of valid legal documentation confirming your legal authority to authorize BCHS to disclose the Patient's medical records (*e.g.,* Power of Attorney for Personal Care Form, copy of Will and Testament).

Name of Patient/Person with Legal Authority to Authorize Release	Signature
Substitute Decision-Maker's Relationship to Patient	Date (DD/MM/YYY)

Interpreter

If the patient does not read or understand English, this Form must be interpreted for the patient and attest as follows:

I _____ agree that I have made best efforts to interpret this Form for the Patient and have answered the Patient's questions about the Form to the best of my ability, in consultation with BCHS as necessary.

Interpreter Name	Signature
Interpreter's Relationship to Patient	Date (MM/DD/YYY)

ADDITIONAL INFORMATION

AUTHORIZATION / WITHDRAWAL OF CONSENT

This authorization will be valid for ***90 days from the date this Form was signed*** and may be withdrawn at any time, except with respect to actions already taken before the consent was withdrawn.

SUPPORTING DOCUMENTATION

To validate the Requestor's identity and to ensure the Requestor has legal authority to authorize the release of the Patient's personal health information, the completed copy of the Consent to Release Personal Health Information Form must be accompanied by the following documents:

a) If Patient is requesting release: a copy of a valid government issued ID (driver's license or OHIP card) (*note: this will not be kept in the Patient's medical record*);

b) If another person is requesting release:

   i. a copy of a valid government issued ID for **both** the Patient and the person requesting the release of the Patient's personal health information (*note: this will not be kept in the Patient's medical record*);

   ii. a copy of valid legal documentation confirming your authority to authorize BCHS to release the Patient's personal health information (*e.g.*, Court Order, Power of Attorney for Personal Care; first and last page of a Will or a Certificate of Appointment naming the Requestor as the

estate representative/executor); and

iii. where applicable, a formal letter of request from the law office or insurance company.

FEES

BCHS is permitted to charge administrative fees reasonably incurred to recover costs associated with preparing and delivering copies of requested records. Please visit our FAQ for the fee schedule, which may be updated from time to time.

ConnectMyHealth

Patients may access health record information through ConnectMyHealth. ConnectMyHealth is a digital health solution that provides you with an online, single access channel to view your health records from many hospitals in southwestern Ontario. More information can be found here.

QUESTIONS

Please direct questions regarding this Form to the Release of Information Office at: roi@bchsys.org.

Copies of the completed Form and supporting documentation must be mailed or emailed to:

Release of Information Office
Brantford General Hospital
200 Terrace Hill Street
Brantford, ON N3R 1G9
Email: roi@bchsys.org