niagarahealth

Extraordinary Caring. Every Person. Every Time.

Consent to Disclose, Transmit, Access or Examine Personal Health Information

☐ Fort Erie ☐ Niagara Falls ☐ Port Colborne ☐ St. Catharines ☐ Welland

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

Records to be Accessed:

Patient: _____

Date of Birth (dd/mm/yyyy): _____

Health Card Number: _____

Phone Number: _____

Address: _____

City: _____ Postal Code: _____

Recipient of Records:

☐ **Patient** ☐ **SDM** ☐ **Other** (specify): _____

Name: _____

Home Number: (_____) _____

Fax Number: (_____) _____

Address: _____

City: _____ Postal Code: _____

Records to be Disclosed:

Personal Health Information relating to the following treatment or admission: (*Specify health information and dates of service*)

_____

_____

_____

_____

How would you prefer to access this information?

☐ Receive hard copies of originals

☐ Examine requested originals in the facility

Reason for Request and Release of Information:

I, _____ hereby authorize Niagara Health to disclose the aforementioned health information to the recipient indicated for the purpose of:

☐ **Ongoing Care** ☐ **Personal** ☐ **Legal** ☐ **Insurance** ☐ **Other (specify):** _____

_____ _____

Signature of Patient or Substitute Decision Maker Date (dd/mm/yyyy)

_____ _____

Signature of Witness Date (dd/mm/yyyy)

NOTE: A substitute decision maker (SDM) is a person authorized under PHIPA to consent, on behalf of an individual, to disclose personal health information about the individual. This Consent for Access to Disclosure will be valid for a three(3) month period as of the date of the signature unless otherwise specified. This authorization may be withdrawn at any time by written notification to the hospital, but is not retroactive to information released before consent is withdrawn.

Hospital Use Only:

Verification of identity of individual consenting to access / disclosure;

Form of ID: ☐ Driver License ☐ Passport ☐ Health Card ☐ Other: _____

ID Checked By Name: _____ Signature: _____

Fee: $30.00 (Basic Search Fee, non–refundable)+ $0.25 per page after 20.

Final Bill: _____ Date Released:(dd/mm/yyyy)_____

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www.niagarahealth.on.ca

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Chart Copy – Do Not Destroy