Eastern Health

Health Information Services and Informatics

Consent for Release/Request of Personal Health Information

(Submission instructions on reverse)

PATIENT / RESIDENT/ CLIENT IDENTIFICATION:

Name: _____ Health Care Number: _____
Patient/Resident/Client

DOB: _____ Mother's Name: _____
DD/MONTH/YYYY

PLEASE COMPLETE SECTION A OR B AS APPLICABLE

A. INFORMATION REQUEST FOR ONGOING CARE & SERVICE BY TREATING HEALTHCARE PROVIDERS

_____
Name of Healthcare Provider / Program

_____ _____ _____
Mailing Address City/ Province Postal Code

_____
Name and phone number of Contact person.

☐ **This is an URGENT REQUEST required for care today**

B. PERSONAL OR THIRD PARTY REQUESTS (See back for detailed explanation)

I hereby authorize Eastern Health to ☐ Release ☐ Request Personal Health information ☐ to ☐ from:

_____
Name

_____ _____ _____
Mailing Address City/ Province Postal Code

_____ _____
Name and phone number of Contact person. Purpose of Request

INFORMATION DESCRIPTION

Description of information being requested or released: _____

_____

_____

Limited Access or Restriction Instructions:(specify) _____

PERMISSION

This authorization will expire in _____ days, and must be submitted to Eastern Health within 90 days of dated signature.
This authorization may be revoked in writing at any time prior to the expiration date, except where action has already been taken.

Date: DD/MONTH/YYYY **Signature:** _____
Original Signature of patient/client/resident or Authorized Representative with supporting documents.

DELIVERY OF INFORMATION

Information will be mailed via Canada Post unless requestor makes arrangements for pick up in person.
In emergent or urgent situations, faxing or emailing of information is available. :

☐ Faxed to the number provided below**. ☐ E-mailed to address provided below**

** Sending personal health information by fax or email carries a potential risk of improper or inadvertent disclosure.

_____ Signature and Date: DD/MONTH/YYYY
Please print fax number or e-mail address in space above Please sign and date accepting risk explained above.

For Office Use Only:

Processed by: _____ _____
Please sign name Please print name

Date: DD/MONTH/YYYY Program / Department: _____

This request will be retained as part of the Health Record

Eastern Health acknowledges and respects the privacy of individuals. This personal information is being collected under the authority of Sections 32 and 33 of the *Access To Information and Protection of Privacy Act,* and will be used for processing your request for the release of Health Information. Please direct any questions about this collection to: Privacy Officer, Eastern Health, Quality and Risk Management, 12th Floor, Southcott Hall, 777-8025. ch-0017 2010/11

Requests for personal health information must be made in writing.

Prior to the release of information, the patient/resident/client must be positively identified. It is the responsibility of the Release of Information staff or agent designated to release information to verify at least 3 identifiers approved by Eastern Health.

- Name
- MCP/Unit Number/Health Care Number
- Photo ID
- Date of Birth
- Mother's Name

Information will be mailed to the patient/resident/client's address as recorded on registration, or picked up in person. When arriving in person, a photo or two other pieces of ID will be required.

Section A: While in the course of treatment and or service, a custodian, healthcare provider or other Regional Health Authority, either within or outside the Province, may have access to a Patient/Resident/Client's Personal Health Information, without written consent. The preferred method of releasing information is by mail. Information may only be faxed when required for **Immediate** or **Urgent** care.

Section B: Requests can be broken into 2 different types: Third Party and Personal Requests

Third Party Requests

Personal health information may be released/disclosed by authorized Eastern Health staff or agents with the original signed consent of the patient/resident/client, or authorized representative, or when required or permitted by Law.

Personal Requests

Upon written request Eastern Health will allow access or provide copies of personal health information to a patient/resident/client or authorized representative about themselves or their minor children. Release of information will not be denied except in circumstances described and defined by the Personal Health Information Act.

Third parties are individuals other than the patient/resident/client and those involved in the circle of care. Third parties include but are not limited to:

- Lawyers
- Insurance Companies
- Member of the House of Assembly
- Family
- Employer
- Schools
- Parents & Guardians
- Power of Attorney

Applicable charges will be applied to requests according to Eastern Health fee schedule. A copy is available.

INFORMATION DESCRIPTION: give detailed description of the information to be released, when possible include site/program/service/department and period of when the information was collected.

Patient/resident/client have the right to limit the amount of information they wish to release. To limit access, the patient/resident/client must, provide instruction or describe the information that may not be released.

FAXING AND E-MAIL RISKS

Faxing and e-mailing have security weaknesses. To safeguard against improper or inadvertent access Eastern Health has created policies to govern this method of information exchange or disclosure.

Please submit your request to: