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

Please ensure that the consent form needs to be signed, dated within 90 days and witnessed.

- Administrative Fee (Please see our THP Website for more details)
- One piece of government issued photo ID for the requester in order to validate signature/ identity

We are required to respond within 30 days once all requirements are met for the request. The Release of Information office will contact you when the records are ready to be released/ picked up.

Section 1: Records to be Accessed

Complete this section with the patient's 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, lawyer etc.), their information must be completed in this section.

Section 3: Records to be Disclosed

Provide the date(s) of visit(s) and check off which records you are looking to obtain. If what you are looking for is not listed in the options provided; check off "Other" and list in detail what you are specifically looking for.
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.

Children under the age of 12:

- The custodial parent must print their name and sign the form

Substitute Decision Maker (SDM):

- If you are the SDM, you must print your name and sign this section and provide the **Power of Attorney of Personal Care** Document. This is only acceptable if the patient is incapable of signing for themselves and are alive.
- If you are making a request for records of a deceased patient, the executor's information must be completed in this section. The executor will be asked to provide a copy of the will. If no will exists, a Certificate of Appointment of Estate Trustee will be required.
  ***NOTE: Only HAND-WRITTEN signatures are accepted at this time; E-SIGNATURES are not permitted**

Section 6: Interpreter (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 addresses and fax numbers.

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: ____
Phone Number: ____
Fax Number: ____
Address: ____

SECTION 3 - Records to be Disclosed

Visit Dates(DD/MM/YYYY): ____

☐ Visit List ☐ Operative Report
☐ Emergency Visit ☐ Nursing Notes
☐ Diagnostic Imaging Reports ☐ Birth Records
☐ Lab
☐ Notes (Consultations, Discharge Summary) ☐ Imaging CD
☐ 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) Signature: ____ Date(DD/MM/YY): ____
☐ Custodial Parent/Guardian Name: ____ Signature: ____ Date(DD/MM/YY): ____
☐ SDM Name:* ____ Relation to Patient: ____ Signature: ____ Date(DD/MM/YY): ____
☐ Witness Name: ____ Signature: ____ 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.

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 ☐ Other: ____

ID Checked by: Name: ____

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Email: releaseofinformation@thp.ca
Mississauga Hospital: 100 Queensway West, Mississauga Ontario, L5B 1B8 Phone: 905-848-7181, option 8 Fax: 905-848-7677
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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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:

____

Phone Number:______________________________

Fax Number:______________________________

Address:

____

SECTION 3 - Records to be Disclosed

Visit Dates(DD/MM/YYYY):______________________________

- Visit List
- Emergency Visit
- Diagnostic Imaging Reports
- Lab
- Notes (Consultations, Discharge Summary)
- Operative Report
- Nursing Notes
- 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) Signature: ______________________________ Date(DD/MM/YY): ______________

Custodial Parent/Guardian Name: ______________________________ Signature: ______________ Date(DD/MM/YY): ______________

SDM Name:* ______________ Relation to Patient:______________ Signature: ______________ Date(DD/MM/YY): ______________

Witness Name:______________________________ Signature: ______________ 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.

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Interpreter Name: ______________________ Interpreter Signature: ______________________ Date(DD/MM/YY): ______________

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ID Checked by: Name:______________________________

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