Arbour Family Medical Centre

Consent to Disclose Personal Health Information

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

This form is to be used for the purpose of authorizing someone other than yourself, to communicate with our staff, with regard to your medical information. ***(See reverse for additional information)***

1. Primary Patient

Complete in Full

Name (Last, First, Middle Initial)		
Street Address		Telephone Number (xxx) xxx-xxxx
City	Province	Postal Code
Date of Birth (mm/dd/yyyy)	Email Address	

2. The person listed below is authorized to access my medical information

Name (Last, First, Middle Initial)		
Street Address		Telephone Number (xxx) xxx-xxxx
City	Province	Postal Code
Date of Birth (mm/dd/yyyy)		

Relationship: ❍Spouse/Partner ❍Guardian ❍Power of Attorney ❍Father ❍Mother
❍Son ❍Daughter ❍ ____________________In Law ❍Other ______________________

3. Information to be Released

❍Telephone/Verbal Communication (all subjects)
❍Only for the Following Subject: ____
❍All Subjects Except for the Following: ____________________________________
❍I AM REVOKING MY CONSENT TO DISCLOSE INFORMATION TO THE ABOVE PERSON NAMED

A separate request (completed Release of Medical Records form) will be required for a copy of medical documentation. A copy fee may apply.

4. This Authorization will remain in effect until revoked by you either verbally or in writing.

If you wish to limit the duration of this Authorization, please specify the end date below:

❍End Date: ____

5. **I authorize release of my medical information in accordance with the specifications listed above. A photocopy or image of this Consent shall be valid as the original.**

6. Signature of Patient ______________________________ Date ______________

Reviewed by Chief Privacy Officer: ❍Yes ❍No Date: ________________

Additional Information Regarding Disclosure of Patient Medical Information

Privacy regulations require your health care team not divulge any information to unauthorized persons. In today's world, it is common for a spouse or partner to arrange appointments for their family members, to check if they should come back for a follow-up, etc. It is not permissible for a spouse to act on your behalf unless authorized and completed through the same channels as the patient. We require **written consent** to be on file.

By default, a parent or guardian is assumed to have authorization for a minor. It is permissible for a parent or legal guardian to manage these tasks for a minor, unless the minor is capable of making their own health care decisions and chooses to revoke consent. Children that are 16 years of age or older must also grant authorization to a parent or guardian. It becomes difficult to manage this if the surnames of any of the parents are different than the minors, resides at a different residence or there are rules regarding custody. In these cases, please supply full details in writing.

Revocation

You have the right to revoke this Authorization, in writing, at any time before it ends. However, your written revocation will not affect any disclosures of your medical information that have already been made, in reliance on this authorization, before the time you revoke it. In addition, if this Authorization was obtained for the purpose of insurance coverage, your revocation may not be effective in certain circumstances where the insurer is consenting a claim. Your revocation must be made in writing and addressed to:

Arbour Family Medical Centre Inc., 281 Stone Road East, Guelph, Ontario N1G 5J5

Signatures

Generally, if you are 16 years of age or older, or capable of making your own health care decisions, you are the only person who is permitted to sign a form to authorize the disclosure of your medical information. A spouse cannot authorize disclosure of medical information on your behalf unless they have legal rights to do so.

Please drop off, fax, or mail via Canada Post the completed form to our office. The signed form will be added to your electronic medical record.

Mail To: Arbour Family Medical Centre Inc., 281 Stone Road East, Guelph, ON N1G 5J5
Fax: (519) 827-0255