MyHealth | CENTRE

CLINIC INFORMATION
Address: _____
_____
Tel: _____
Fax: _____

CONSENT TO DISCLOSE, TRANSMIT, ACCESS OR EXAMINE PERSONAL HEALTH INFORMATION PURSUANT TO THE PERSONAL HEALTH INFORMATION PROTECTION ACT, 2004 (PHIPA)

RECORDS TO BE ACCESSED

Patient Name: _____

Date of Birth (DD/MM/YY): _____

Health Card #: _____

Telephone #: _____

Address: _____

_____

RECIPIENT OF RECORDS

☐ Patient **OR**

Name: _____

Telephone #: _____

Fax #: _____

Email: _____

Address: _____

_____

RECORDS TO BE DISCLOSED

Date(s) of Visit: _____

Type of Records Requested:

☐ Copy of _____ test report

☐ CD of _____ test images/scan

☐ Consultation summary

☐ Other: _____

REASON FOR REQUEST AND RELEASE OF INFORMATION

I _____ hereby authorize
(Patient or SDM)

MyHealth Centre to disclose the aforementioned health information to the recipient indicated for the purpose listed.

☐ Personal ☐ Legal ☐ Insurance

☐ Other (specify): _____

_____

_____
Signature of Patient or Substitute Decision Maker

_____
Signature of Witness

_____
Date (DD/MM/YYYY)

If the person signing is not the patient, please state the relationship and authority to do so.

_____
Relationship to Patient

_____
Authority (i.e.: Power of Attorney or Authorization Form)
*Photo ID required for proof of identity documentation

Note: (SDM) a substitute decision-maker 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 month period as of the date of the signature unless otherwise specified.
This authorization may be withdrawn at any time by written notification to MyHealth Centre, but is not retroactive to information released before consent is withdrawn.

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