ByWard
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# CONSENT TO AUTHORIZE DISCLOSURE OF MEDICAL INFORMATION

**Pursuant to the Personal Health Information Act, 2004 (PHIPA), this form is for the purpose of authorizing someone other than yourself to communicate with our staff with regard to your medical information. (See page 2 for details).**

**1. Patient providing authorization (PLEASE COMPLETE IN FULL)**

| | | | |
|---|---|---|---|
| Name – Last, First | | | Date of Birth |
| Street Address | | | City |
| Province | Postal Code | | ☎ |

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

| | | | |
|---|---|---|---|
| Name – Last, First | | | |
| Street Address | | City | Province |
| Postal Code | ☎ | Relationship with patient (ie: spouse, partner, father, mother, guardian, son, daughter, in-law, power of attorney, etc.): | |

**Additional person listed below is also authorized to access my medical information:**

| | | | |
|---|---|---|---|
| Name – Last, First | | | |
| Street Address | | City | Province |
| Postal Code | ☎ | Relationship with patient (ie: spouse, partner, father, mother, guardian, son, daughter, in-law, power of attorney, etc.) | |

3. Information to be released:

- ☐ Only for appointment booking and rescheduling.
- ☐ All information (including telephone/verbal communication).
- ☐ All information except for the following: _____

4. This authorization will remain in effect until revoked by you in writing. If you wish to limit the duration of this authorization, please specify end date: _____

5. I authorize release of my medical information in accordance with the specifications listed above. I will receive/retain a copy of my signed authorization. Documented (signed or verbal) consent will be recorded in my medical chart. A photocopy of this consent shall be valid as the signed original.

Signature of Patient _____ Date _____

# ADDITIONAL INFORMATION REGARDING CONSENT TO DISCLOSE PATIENT MEDICAL INFORMATION

Privacy regulations require your health care team to not divulge any information to unauthorized persons.

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. However, it is not permissible for a spouse to act on their spouse's behalf unless authorized. For this, we require written consent to be on file.

Similarly, it is assumed and permissible for a parent or legal guardian to coordinate and manage the health care needs for a child. However, under PHIPA (Personal Health Information Protection Act, 2004) there is no defined age of consent in the province of Ontario. Therefore, patients under 16 years of age who are capable of understanding the relevant information and the consequences pertaining to their own health care may, at any time, elect to designate an individual(s) to be authorized to access their health information. This written consent is required to be on file.

Patients 16 years of age or older are required to provide authorization to a parent or guardian or other designate of choice to access their medical information should they choose to do so, per the Health Care Consent Act, 1996. This also requires written consent to be on file.

**Names, Residence, Custody**
It becomes difficult to manage cases where spouses' surnames are different, the surnames of any of the parents are different from their children, family members reside at different residences, custody agreements are in place, etc. In these cases, full details must be provided in writing and kept on file.

**Revocation**
You have the right to revoke this authorization, in writing, at any time before it ends. However, your revocation will not affect any disclosures of your medical information that have already been made, in reliance of this authorization, before the time you revoke it. It may not be effective in certain circumstances where the insurer is contesting a claim. However, written revocation or any questions should be addressed to: Privacy Officer at privacyofficer@opih.ca.

**Signatures**
You are the only person who is permitted to sign a form to authorize the disclosure of your medical information. A spouse, parent or guardian cannot authorize disclosure of medical information for you unless they have legal rights to do so.

**THIS FORM MUST BE SIGNED BY YOU, THE AUTHORIZING PATIENT.** THIS SIGNED FORM WILL BE RECORDED IN YOUR MEDICAL RECORDS.