RSMC
RIVERSIDE SOUTH MEDICAL CENTRE
AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

3-665 Earl Armstrong Road, Ottawa, ON K1V 2G2
Office Phone: (613) 822-0411 Fax No: (613) 822-1399

1. PATIENT INFORMATION – COMPLETE IN FULL (16 years of age and older):

Name – Last name, First Name, Middle Initial				**Date of Birth (MM/DD/YY)**
Street Address				**Telephone Number**
City	**Province**	**Postal Code**	**Doctor's Name**	**Health Card #**

2. THE PERSON LISTED BELOW IS AUTHORIZED TO ACCESS MY MEDICAL INFORMATION:

Name – (Last, First, Middle Initial)		
Street Address		Telephone Number
City	Province	Postal Code
Relationship – please check the appropriate spot (if more than one, a separate form MUST be completed): ___ Spouse/Partner ___ Guardian ___ Power of Attorney ___ Other: _____ ___ Father ___ Mother ___ Son ___ Daughter		

3. TYPE OF INFORMATION TO BE RELEASED: (Check all applicable categories)

Initial appropriate box	
	Telephone/ verbal communication (all subjects)
	Appointment Booking & Confirmation
	Health Myself Patient Portal: Managing appointments & Communicating with clinic
	Only for the following subject(s): _____ _____
	All subjects except for the following: _____ _____

4. THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL REVOKED BY YOU.
If you wish to limit the duration of this authorization, please initial and specify the end date below.
Initial: _____ End Date: _____ (MM/DD/YY)

5. SIGNATURE: I authorize release of my medical records in accordance with the specification listed above. A photocopy of this consent shall be valid as the original.

Patient Signature: _____ **Date:** _____
(If signed by person other than patient, state relationship and authority to do so)

Copy to: Patient ____

ADDITIONAL INFO - DISCLOSURE OF PATIENT MEDICAL INFORMATION

CONFIDENTIALITY OF PERSONAL HEALTH INFO

In accordance with the Personal Health Information Act, regulations require us NOT to divulge any information to unauthorized individuals. Situations may arise where physicians are asked by a family member or friend about the condition of a patient. It is also 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 permissible for a patient or legal guardian to manage these tasks for a minor. It is however **NOT** permissible for a spouse to act on your behalf unless authorized to do so.

Patients are permitted to restrict the disclosure of such information. For this reason and in conjunction with the College of Physicians and Surgeons of Ontario regulations, we are required to obtain written express consent from the patient before we disclose the patient's personal health information. It is permissible for a parent or legal guardian to manage these tasks for a minor, and by default a parent or guardian is assumed to have authorization for a minor. It becomes difficult to manage these if the surnames of any of the parents are different than the minors and/or they reside at a different residence, or, there are rules regarding custody. In these circumstances, we require full details in writing.

Children sixteen (16) years of age or older **MUST** also grant authorization to a parent or guardian.

Revocation. You have the right to revoke this authorization, in writing, at any time before it ends. Your revocation must be made in writing and addressed to Riverside South Medical Centre.

Signatures. If you are 16 years of age or older, you are the only person who is permitted to sign a form to authorize the disclosure of your medical information. If you are under the age of 16, your parents or guardian must sign this form for you. A spouse cannot authorize disclosre of medical information for you unless they have legal rights to do so.

PLEASE DROP OFF, FAX, SCAN OR SEND THROUGH THE POMELO PORTAL THE COMPLETED AUTHORIZATION FORM TO OUR OFFICE.
THE SIGNED FORM WILL BE ADDED TO YOUR MEDICAL RECORDS.

MAIL TO: **3 - 665 Earl Armstrong Rd, Ottawa ON K1V 2G2**
FAX NUMBER: **(613) 822-1399**