Authorization for Release of Personal Health Information

**Patient Name:**

**Address:**

**Birth date:**

I hereby authorize NP med inc. to disclose the following personal health information:

Health Record

Confirmation of Services

Visit Dates

Other:

(description of personal health information to be disclosed)

to:

(name & address of person/agency requesting information)

## Method of disclosure:

Hard copy (

By Mail **or**

Pick-up)

View original documentation

I understand that this personal health information is to be used **only** by the recipient for the purposes of:

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Signature of **Patient/Substitute Decision Maker** Please Print Name

Relationship to Patient:

Self Parent Guardian **\*** Power of Attorney **\*** Legally Appointed Designate **\***

Substitute Decision Maker (please specify):

## NB: A copy of the document to support your status/relationship is required, i.e. Power of Attorney for Personal Care or Will/Estate Trustee (see section 6 on page 2 for more details) \*

Signature of **Witness** Please Print Name

Date (dd/mm/yy) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Instructions for Completion of Authorization for the Release of Personal Health Information**

This form documents consent of an individual to disclose health or personal information in compliance with the Personal Health Information Protection Act, November 2004 (PHIPA). It is to be **completed in full by the capable patient, or in the case of an incapable patient, their Substitute Decision Maker representative** before disclosure and provided to NP med inc.

### Description of the Personal Health Information to be Disclosed

Be as specific about the type and dates of information as you can if you wish to limit the disclosure.

### Recipient of Information and Description of Purpose

Indicate the name of the person or agency including mailing address, who is to receive the information and state why you wish to release your information to this recipient. Include in this section any conditions limiting the purpose.

### This authorization must contain the original signature of:

* + the patient or the substitute decision maker \*(see below for ranking), and
  + the witness to the patient/substitute decision maker(s) signature. The witness must be present for the signing of the authorization and know the patient/substitute decision maker.

1. This authorization may be rescinded or amended in writing at any time except where action has been taken in reliance on the authorization.
2. Authorization is valid until requirements of the request are met.
3. If the patient has died, you must obtain consent from the patient’s estate trustee(s) or someone who is in charge of administering the patient’s estate. Please provide a copy of the will. NB: The entire will is not required; only the section naming the Estate Trustee and the signatures and date.

### \*Ranking of substitute decision maker:

* guardian (if the guardian has the authority to make such decisions),
* attorney for personal care or attorney for property (if the attorney has the authority to make such decisions),
* representative (appointed by the Consent and Capacity Board under the Health Care Consent Act, 1996 if the representative has the authority to give the consent),
* spouse or partner,
* child or custodial parent, or children aid’s society or other person legally entitled to give or withhold consent in place of a parent. This paragraph does not include a parent who has only a right of access. If a children’s aid society or other person is lawfully entitled to give or withhold consent in place of a parent, this paragraph does not include the parent,
* parent with access rights
* brother or sister, and
* any other relative (related by blood, marriage or adoption).

### Time for Response:

* NP med inc. will respond to requests for personal health information as soon as possible, and no later than 30 days after receiving a request. If NP med inc. is unable to respond to the request within 30 days, NP med inc. will notify the requestor in writing, setting out the length of the extension and the reason for the extension.

### Direct completed authorizations to:

NP med inc.

15 Sandford Crescent

Whitby, Ontario, L1R 2R7

Phone: 905-767-1061; Fax: 905-743-6186