AUTHORIZATION FOR <u>DISCLOSURE</u> OF MEDICAL INFORMATION

MANOTICK FAMILY HEALTH ORGANIZATION
5230 Mitch Owens Road Manotick, ON K4M 1B2
Office Phone: (613) 692-2571 Fax No: (613) 692-0271

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, MI)		
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 ____ _________________ in law

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

Initial appropriate box	
	Telephone/verbal communication (all subjects)
	Only for the following subject(s): ______________________________ ______________________________
	All subjects except for the following: ______________________________ ______________________________

A separate request (completed documentation release 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.

If you wish to limit the duration of this authorization, please initial and specify the end date below.
_____ 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 ___

Issued: June 2018

ADDITIONAL INFORMATION REGARDING DISCLOSURE OF PATIENT MEDICAL INFORMATION

CONFIDENTIALITY OF PERSONAL HEALTH INFORMATION

In accordance with the Personal Health Information Protection 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 parent 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 this 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 instances, 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. However, your written revocation will not affect any disclosures of your medical information that the person(s) and/or organization(s) listed on the reverse side of this form have already 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 contesting a claim.

Your revocation must be made in writing and addressed to: 5230 Mitch Owens Road, Manotick, ON K4M 1B2

Copying Fees. There may be a copy fee charge for disclosure and release of medical information as authorized by your signature. The copy charges must be paid before the documentation is released.

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 parent or guardian must sign this form for you. A spouse can not authorize disclosure of medical information for you unless they have legal rights to do so.

PLEASE DROP OFF, FAX, SCAN OR MAIL THE COMPLETED FORM TO OUR OFFICE.

THE SIGNED FORM WILL BE ADDED TO YOUR MEDICAL RECORDS.

MAIL TO: **5230 Mitch Owens Road Manotick, ON K4M 1B2**
FAX NUMBER: **(613) 692-0271**