AUTHORIZATION TO TRANSFER MEDICAL RECORDS
FROM THE 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 (See reverse side for instructions):*

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. RECORDS RELEASED FROM:

Name – (i.e. Heath Facility, Physician, etc.)		
Street Address	Fax Number	Telephone Number
City	Province	Postal Code

3. RECORDS RELEASE TO:

Name – (i.e. MMC doctor stamp, Insurance Company, Lawyer, Physician, Self, etc.)

4. INFORMATION TO BE RELEASED: (Check all applicable categories)

____ A Summary of the Record	____ Lab Reports	____ Allergy Records
____ Telephone/Verbal Communication	____ X-Ray Reports/Films	____ Counseling & Consultation Visits
____ Immunization Records	____ Clinic Records pertaining to outpatient treatment _____	
Complete Copy of All Records and/or Other (Specify):_____		
For the following dates: _____		

5. TIMEFRAME: This authorization will remain in effect until this request is processed **unless** you specify this authorization will be effective for an additional time period. Written consent is required to revoke this request.

Additional time period required?____ (Y OR N). If so, specify timeframe: _____

6. SIGNATURE: I authorize release of my medical records in accordance with the specification listed above. I understand that I have a right to inspect and receive a copy of the disclosed material. A photocopy of this consent shall be valid as the original. I understand that any costs for this service shall be my responsibility.

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

Copy to: Patient __

Dated: June 2018

ADDITIONAL INFORMATION REGARDING DISCLOSURE OF PATIENT MEDICAL INFORMATION

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*

Right to Inspect. You have the right to inspect or copy the medical information whose disclosure you are authorizing.

***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.

This form must form part of your medical record, and any associated charges paid, BEFORE the documentation is released.

PLEASE FAX OR MAIL THE COMPLETED FORM TO THE PROVIDER SHOWN IN SECTION 2.

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.

The law recognizes "mature minors"; that is, patients under 16 who are able to understand the risks and benefits of a specific intervention. They can give/remove consent for transfer of records if they wish, including blocking access to their record by their parents/guardian.

Mature minors MUST also grant authorization to a parent or guardian.