CONSENT TO DISCLOSE HEALTH INFORMATION

Place Patient Label with Barcode Here

Unit Name: ____________________
Fax Number: __________________________

CONSENT TO DISCLOSE HEALTH INFORMATION

I, ________________________________ , hereby authorize **Thunder Bay Regional Health Sciences Centre**

to disclose the following personal health information:

____

____

(Description of personal health information to be disclosed and dates of contact/hospitalization)

to ____

____

(Name and address of person/agency requesting information)

from the records of ____

(Name of Patient) **(Birth date)**

Mailing Address of Patient: ____

____

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

____

____

I hereby waive any and all claims against the Thunder Bay Regional Health Sciences Centre in connection with the disclosure of this personal health information.

Signed by: ____________________________________ ____

(Patient or Substitute Decision-Maker **(Relationship to Patient)**

Date: ____

(Note: Include copies of documents that provide your authority as a substitute decision-maker.)

Place Patient Label with
Barcode Here

Guidelines:

1. Refer to Procedure HIS-08.

2. This form is to be used for release of patient information.

3. This Consent to Disclose Health Information must contain the original signature of:
   a) The patient, if capable or;
   b) For individuals under the age of 16, authorization will be accepted from parent(s)/legal guardian(s) unless we are aware that the parent(s)/legal guardian(s) and the patient's wishes are not the same and that the patient is capable of consenting. In this case, a request must be made by the patient. If there is reason to doubt the custodial relationship of the requestor, proof of custody will be required.
   c) If the patient is not capable of consenting to the disclosure of personal health information, the following order for substitute decision makers is:

- Guardian
- 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, if the representative has the authority to give the consent.)
- Spouse or partner
- Child, custodial parent, or Children's Aid Society or other person legally entitled to give or withhold consent in place of a parent. (Note: Where this is the situation, the child's parent cannot consent on behalf of the child.)
- Brother or sister
- Other relative, related by blood, marriage or adoption

4. This Consent to Disclose Health Information will be considered valid for a period of up to three months from the date of signing unless otherwise stated.

5. The patient may state on the Consent to Disclose form any information which he or she does not wish to be released by this authorization.

6. This authorization may be rescinded or amended in writing at any time prior to the expiration date, except where action has been taken in reliance on the authorization.

7. The authorization may list more than one agency providing the individual understands this.

8. If substitute decision maker provides authorization, TBRHSC staff will ensure copies of documents are attached.

9. Form to be filed in the patient's health record. (If an inpatient, form to be filed under the Miscellaneous Section of the patient's health record).