

CONSENT TO AUTHORIZE DISCLOSURE OF MEDICAL INFORMATION

Kingston Heart Clinic
460 Princess Street Kingston ON K7L 1C2

Pursuant to the Personal Health Information Act, 2004 (PHIPA), this form is to be used for the purpose of authorizing someone other than yourself to communicate with our staff with regards to your medical information.

1. Patient providing Authorization (PLEASE COMPLETE IN FULL)

Name - Last, First, MI: _____

Street Address (and mailing if different) _____

City Province: _____ Postal Code _____

Telephone # (____) _____ Date of Birth mm/dd/yyyy _____

2. The person listed below is authorized to access my medical information:

Name - Last, First, MI: _____

Street Address (and mailing if different) _____

City Province: _____ Postal Code _____

Telephone # (____) _____ Date of Birth mm/dd/yyyy _____

Additional person listed below is authorized to access my medical information:

Name - Last, First, MI: _____

Street Address (and mailing if different) _____

City Province: _____ Postal Code _____

Telephone # (____) _____ Date of Birth mm/dd/yyyy _____

Relationship (Check one): Spouse/Partner Guardian Father Mother Son Daughter

Power of Attorney Other _____

3. **INFORMATION TO BE RELEASED:** (check applicable)

_____ All Information (including telephone/verbal communication and email)

_____ ONLY for the following subject:

_____ All information EXCEPT the following subject:

4. This authorization will remain in effect until revoked by you in writing. If you wish to limit the duration of this authorization, **please specify end date:**

End Date: 1 yr 6 mo 3 mo Other: _____

5. I authorize release of my medical information in accordance with the specifications listed above. I will receive/retain a copy of this authorization. A photocopy of this consent shall be valid as the original.

6. Signature of Patient _____

Witnessed by: _____ (staff initials)

Date _____

ADDITIONAL INFORMATION REGARDING

CONSENT TO DISCLOSE PATIENT MEDICAL INFORMATION

Privacy regulations require your health care team not divulge any information to unauthorized persons.

Family Members

In today's world, it is 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. However, it is not permissible for a spouse to act on their spouse's behalf unless authorized. For this, we require **written consent** to be on file.

Similarly, it is assumed and permissible for a parent or legal guardian to coordinate and manage the health care needs for a child. **However, under PHIPA (Personal Health Information Protection Act, 2004) there is no defined age of consent in the province of Ontario.** Therefore, patients under 16 years of age who are capable of understanding the relevant information and the consequences pertaining to their own health care may, *at any time*, elect to designate an individual(s) to be authorized to access their health information. This **written consent** is required to be on file.

Patients 16 years of age or older are required to provide authorization to a parent or guardian or other designate of choice to access their medical information *should they choose to do so*, per the Health Care Consent Act, 1996. This also requires **written consent** to be on file.

Names, Residence, Custody

It becomes difficult to manage cases where spouses' surnames are different, the surnames of any of the parents are different from their children, family members reside at different residences, there are rules regarding custody, etc. In these cases, full details must be provided in writing and kept on file.

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 have already been made, in reliance of this authorization, before the time you revoke it. It may not be effective in certain circumstances where the insurer is contesting a claim. Your revocation must be made in writing and addressed to: *Privacy Officer, Kingston Heart Clinic; 460 Princess Street; Kingston ON K7L 1C2*

Signatures

You are the only person who is permitted to sign a form to authorize the disclosure of your medical information. A spouse, parent or guardian cannot authorize disclosure of medical information for you unless they have legal rights to do so.

THIS FORM MUST BE SIGNED BY YOU, THE AUTHORIZING PATIENT, AT ONE OF OUR LOCATIONS BELOW. SHOULD YOU BE UNABLE TO ATTEND IN PERSON, PLEASE CONTACT ONE OF OUR OFFICES BELOW.

THE SIGNED FORM WILL BE ADDED TO YOUR MEDICAL RECORDS.