Toronto Metropolitan University Integrated Health Centres

How to Complete the Consent to Disclose, Transmit, Access or Examine Personal Health Information Form

To request a copy of your Personal Health Information, you must provide the following:

- A completed Consent to Disclose, Transmit, Access or Examine Personal Health Information form.
  - Please ensure that the consent form is signed, dated within 90 days.
- Administrative Fee.
- One piece of government issued photo ID for the requester in order to validate signature/ identity.
  - We are required to respond within 30 days once all requirements are met for the request.

The IHC will contact you when the records are ready to be released/ picked up.

Requests can be emailed to **privacy@torontomu.ca**

Authorization Information

This Consent for Access to Disclosure will be valid for a three-month period as of the date of the signature. This authorization may be withdrawn at any time by written notification to the IHC, but is not retroactive to information released before consent is withdrawn. Personal health information will only be disclosed for visits up to the date of signing. We are required to respond within 30 days upon receipt of the complete request. Records will be held for a maximum of 90 days from when you are notified of completion. If they are re-requested, appropriate fees will be applied. Information collected on this form will be used to facilitate the access request process, inform program evaluation and training in accordance with PHIPA. Should you have questions regarding the information collection practices or processes, please contact privacy@torontomu.ca

For Internal Use Only

Verification of identity of individual consenting to access/ disclosure:

Requestor: Form of ID: ☐ Driver's License ☐ Passport ☐ Health Card ☐ Other: _____

Recipient: Form of ID: ☐ Driver's License ☐ Passport ☐ Health Card ☐ Other: _____

Validation of SDM: ☐ Power of Attorney ☐ Will ☐ Other: _____

ID Checked by: Name: _____

CONSENT TO DISCLOSE, TRANSMIT, ACCESS OR EXAMINE PERSONAL HEALTH INFORMATION

Section 1: Records to be Accessed
Complete this section with the patient's information.

Section 2: Recipient of Records
If you are receiving your own Personal Health Information, check If you are releasing your information to another individual (such as your parent, physician, lawyer etc.), their information must be completed in this section.

SECTION 1 - Records to be Accessed

Patient Name: _____

Date of Birth (DD/MM/YY): _____

Health Card Number: _____

Phone Number: _____

Address: _____

Email address: _____

SECTION 2 - Recipient of Records

☐ Patient **OR**
Name of Recipient of Records:

_____

Phone Number: _____

Fax Number: _____

Address: _____

Email address: _____

Section 3: Records to be Disclosed
Provide the date(s) of visit(s) and check off which records you are looking to obtain. If what you are looking for is not listed in the options provided; check off "Other" and list in detail what you are specifically looking for.
If you do not know the exact date(s) of the records you are requesting, provide your best estimate.

Section 4: Purpose
Please check the purpose of the usage of the Personal Health Information. The Personal Health Information should only be used for the purpose indicated

SECTION 3 - Records to be Disclosed

Visit Dates (DD/MM/YYYY): _____

☐ All

☐ Other: _____

SECTION 4 - Purpose

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

☐ Personal ☐ Legal ☐ Insurance

☐ Other _____

Section 5: Method of Delivery

Indicate how you would like to receive the requested records.

SECTION 5 – Method of Delivery

How would you prefer to receive this information? Please select ONE method and indicate with a check mark:

☐ Email (Password Protected File) ☐ Printed Copy ☐ Patient Portal (Telus Health Connect)

All requests are subject to a standard processing fee and additional fees for copying, retrieval and special handling where applicable , including if there are multiple delivery methods selected.

Section 6: Signatures

If you are the patient requesting your own records and are 12 years of age or older, you must sign and date this section.

Children under the age of 12: The custodial parent must print their name and sign the form.

Substitute Decision Maker (SDM):

(SDM) a substitute decision-maker is a person authorized under the Personal Health Information Protection Act to consent, on behalf of an individual, to disclose personal health information about the individual. If you are the SDM, you must print your name and sign this section and provide the Power of Attorney of Personal Care Document. This is only acceptable if the patient is incapable of signing for themselves and are alive. If you are making a request for records of a deceased individual, the executor will be asked to provide a copy of the Will.

If no Will exists, either a Certificate of Appointment of Estate Trustee (without a Will) OR a Notarized letter (signed by Notary Public) Indicating the patient did not have a Will at the time of death and the applicant is the next of kin/ Personal Representative of the patient will be requested.

SECTION 6 - Signatures

☐ Patient (12 years and older) Signature: _____ Date (DD/MM/YY): _____

☐ Custodial Parent/Guardian Name: _____ Signature: _____ Date (DD/MM/YY): _____

☐ SDM Name: _____ Relation to Patient: _____ Signature: _____ Date (DD/MM/YY): _____

SECTION 7 – Interpreter

As the interpreter, I have done my best to accurately translate this form for the person referred above, and will not divulge any information learned during this review.

Interpreter Name: _____ Interpreter Signature: _____ Date (DD/MM/YY): _____