SickKids®

HEALTH INFORMATION MANAGEMENT
The Hospital for Sick Children
555 University Avenue, Room S203, Toronto, ON, M5G 1X8
Telephone: 416-813-7575 Fax: 416-813-5802
Email: releaseofinformation.requests@sickkids.ca

Request / Authorization for Access to / Disclosure of Personal Health Information

I hereby authorize _____
(name of facility releasing information)

to release to _____
(person / facility to whom information is to be sent — name, full address, phone number)

_____

the following information: _____
(description of information to be released)

_____

from the record of _____
(patient's name, address, phone number)

_____

Date of birth _____ Medical Record Number _____
DD-MM-YYYY

Health Card Number _____

The reason for this request is: ☐ Health Care Provider ☐ Lawyer ☐ Insurance ☐ Personal Use
☐ Other _____

NOTE:
In accordance with PHIPA (Personal Health Information Protection Act) patient consent (signed authorization) must be obtained prior to disclosure to a third party. Where the patient is incapable, the parent / legal guardian or substitute decision maker (SDM) may consent. A SDM is a person authorized by PHIPA to consent on behalf of an individual to the disclosure of the individual's personal health information.

_____ _____
Name of patient **(12 years and older)** Signature of patient **(12 years and older)**

_____ _____
Name of parent / legal guardian / SDM Signature of parent / legal guardian / SDM

_____ _____ _____
Date (DD-MM-YYYY) Time (HH:MM) Relationship to patient

The Request / Authorization for Access to / Disclosure of Personal Health Information is valid for 12 months. It can be withdrawn at any time by notification in writing to Health Information Management.

Personal information contained on this form is collected in accordance with the Freedom of Information and Protection of Privacy Act for the purpose of authorizing disclosure of personal health information. Questions about this collection can be directed to the Director of Enterprise Information Management, 416-813-7567.

Office use only

Authority to release: ☐ Circle of Care ☐ Signed consent ☐ Mandatory disclosure: _____

Validated by (HIM staff): _____ ☐ Government ID ☐ Corporate request / Letterhead