CHATHAM-KENT Health Alliance

Chatham Site
80 Grand Ave W
Chatham, On

Wallaceburg Site
325 Margaret Ave
Wallaceburg, ON

Mailing Address:
P.O. Box 2030 Chatham, ON, N7M 5L9

Consent to Disclose Personal Health Information

I _____ hereby authorize the Chatham-Kent Health Alliance to ☐ disclose ☐ obtain the following personal health information:

_____
(Description of personal health information to be disclosed)

located at:

(please check all that apply)

- ☐ Chatham and Wallaceburg Site
- ☐ Psychiatry and Therapy notes(Outpatient Mental Health)
- ☐ Other Facility (please state below):

_____

From the records of: _____
(Print Name of Patient)

_____ _____
(Preferred / Chosen Name) (DOB: YYYY/MM/DD)

During the period of: _____ to _____
(YYYY/MM/DD) (YYYY/MM/DD)

Method of Disclosure: ☐ Electronic ☐ Diagnostic Images on CD ☐ Hard Copy ☐ View Original

To / From: _____
(Name & Address of Recipient of Personal Health Information)

Requestor's Phone Number: _____

Requestor's Email Address: _____

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

_____

If signed by the Substitute Decision Maker, indicate your relationship to the patient:

* Guardian ☐ * Power of Attorney ☐ * Legally Appointed Representative ☐

Spouse ☐ * Custodial Parent ☐ Child ☐ Other: _____
(Please Specify)

*** A copy of the documentation to support your status/relationship is required, (e.g., Power of Attorney for Personal Care, Will/Estate Trustee or Custodial Papers)**

_____ _____
(Signature of Patient/Substitute Decision Maker) (Please Print Name)

_____ _____ _____
(Signature of Witness) (Print Name of Witness) Date (YYYY/MM/DD)

CHATHAM-KENT Health Alliance

Guidelines for Completion of the Consent to Disclose Personal Health Information Form

This form documents consent of an individual to disclose personal health information from and / or to the Chatham-Kent Health Alliance (CKHA) in compliance with the Personal Health Information Protection Act, 2004 (PHIPA). It is to be **completed in full by the capable patient, or in the case of an incapable patient, their Substitute Decision Maker representative.**

1. **Description of the Personal Health Information to be Disclosed**
   - Be as specific about the type, location and dates of information as you can if you wish to limit the disclosure. **NB:** Requests for personal health information from Outpatient Mental Health may require review from a Psychiatrist.
2. **Recipient of Information and Description of Purpose**
   - Indicate the name of the person or agency including mailing address, who is to receive the information, or indicate the name of the person / agency CKHA may obtain records from.
   - State why you wish to release your information to this recipient. Include in this section any conditions limiting the purpose.
3. **This authorization must contain the original signature of:**
   - The patient or the substitute decision maker *(see below for ranking), and
   - The witness to the patient/substitute decision maker(s) signature. The witness must be present for the signing of the authorization.
4. This authorization may be rescinded or amended in writing at any time except where action has been taken in reliance on the authorization. Authorization is valid until requirements of the request are met or three (3) months, which ever comes first.
5. If the patient has died, you must obtain consent from the patient's estate trustee(s) or someone who is in charge of administering the patient's estate. Please provide a copy of the Will. **NB:** The entire Will is not required; only the section naming the Estate Trustee and the signatures and date.

***Ranking of substitute decision maker:**

1. guardian (if the guardian has the authority to make such decisions),
2. attorney for personal care or attorney for property (if the attorney has the authority to make such decisions),
3. representative (appointed by the Consent and Capacity Board under the Health Care Consent Act, 1996 if the representative has the authority to give the consent),
4. spouse or partner,
5. child or custodial parent, or children aid's society or other person legally entitled to give or withhold consent in place of a parent of a patient who is under the age of sixteen (16) and unmarried. This paragraph does not include a parent who has only a right of access. If a children's aid society or other person is lawfully entitled to give or withhold consent in place of a parent, this paragraph does not include the parent,
6. parent with access rights,
7. brother or sister, and
8. any other relative (related by blood, marriage or adoption).

Direct completed consents to:

Health Records Department - Release of Information
Chatham Kent-Health Alliance
80 Grand Ave. W. P.O. Box 2030
Chatham, ON N7M 5L9
Fax: 519-436-2543
Email: ckphipa@ckha.on.ca

Note: When sending the authorization by fax or email, records will not be released until the CKHA has received the original signed authorization. Fees for administration services may apply based on regional fee schedule.