Patient Information Authorization Release

I have reviewed Group Health Centre's written statement concerning the collection, use and disclosure of personal health information.

I understand that Group Health Centre is seeking my consent for it to collect, use and/or disclose my personal health information from me, or from the person acting on my behalf.

I understand that Group Health Centre will only collect, use and disclose my personal health information with my consent (as set out in its privacy policy), unless a particular collection, use or disclosure is permitted or required by law without my consent.

RELEASE OF INFORMATION

You are hereby authorized to release the following information:

_____

(description of information to be disclosed)

To:

_____

(name, address, and phone number of person/agency requesting information)

From the records of:

_____

(name of patient)

_____

(date of birth / medical records number)

Concerning treatment on:

_____

(specify, otherwise complete chart will be forwarded)

_____

(current address)

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

_____

Disclaimer: Please note these may not be copies of the complete medical records. If you wish for further documents to be provided, please identify which documents are requested.

There is an administrative fee associated with the request to obtain a copy of your health record. The fee for copying varies depending on the size of the record and the number of pages copied. A fee estimate can be provided in advance upon request of records.

Signed by: _____

_____

(if signed by person other than patient, note relationship here)

Witness Signature: _____

Date: _____

☐ Information given to patient

☐ Please leave the information requested for pick-up at the front desk of GHC in an envelope marked "Confidential"
NOTE: Photo identification will be required to pick up information requested

Expiry Date of Authorization: _____

This authorization may be rescinded or amended in writing at any time prior to the expiration date, except where action has been taken in reliance on the authorization.

1. This authorization must contain the original signature of:
   - a) the patient;
     the parent or legal guardian if the patient is under 16 years of age and unmarried; or
     the legal representative if the patient is deceased or has been certified mentally incompetent; and
   - b) the witness to the patient's signature.
2. 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.

Is this patient to be disenrolled, that is, will no longer have a Family Physician at Group Health Centre? ☐ No ☐ Yes

If a move is involved, does it apply to any other family members? ☐ No ☐ Yes - please list names below