

How to Complete the Consent to Access Personal Health Information (PHI)

To Request a Copy of your Personal Health Information you must provide the following:

- A completed and signed consent form.
- Form can be mailed, faxed or brought in person by patient (records will not be processed on same day)
- **Patient 16 and over:** Patient must provide supporting documents for verification (two pieces of government issued ID)
- **Minor (under 16): Custodial Parent:** The requestor needs to provide supporting documents for verification (two pieces of government issued ID) and must provide their child's original health card.
- **If one parent has sole custody,** the requestor needs to provide verification of sole custody and two identification documents for verification (two pieces of government issued ID) and their child's original health card.
- **Substitute Decision Maker** must provide supporting documents for verification (i.e. Original Power of Attorney) and the requestor needs to provide supporting documents for identification verification (two pieces of government issued ID).
- The request must be dated within 30 days of our receiving it
- The request will be processed within 30 days
- Administration fee of \$30

Instructions to Complete Consent Form

Section 1: Records to be Accessed:

Complete section with all patient information

Section 2: Recipient of Records:

- If you are receiving your own Personal Health Information, check "patient"
- If you are releasing your information to another individual such as a parent of a minor, the recipient information must be completed (including address).
- If a report is for a doctor's office, the name of doctor and fax number must be recorded and verified

Section 3: Records to be Disclosed:

Check appropriate box

Section 4: Signatures:

- If you are the patient requesting your own records and are 16 years of age or older, you must sign and date this section.
- The requestor needs to provide supporting documents for verification (two pieces of government issued ID)

Children Under the Age of 16:

- The custodial parent must print their name and sign the form.
- In the event that one parent has sole custody, proof of custody must be provided
- The custodial parent needs to provide supporting documents for verification (two pieces of government issued ID) and the child's original health card.

Substitute Decision Maker (SDM)

- If you are the legal substitute decision maker, you must print your name and sign in this section and show the original documents for SDM (for example, Power of Attorney) and provide supporting documents for verification (two pieces of government issued ID) and the show the patient's original health card.

Requests can be mailed, faxed or handed in-person to the Health Records Department at the Below Address

Queensway X-ray and Ultrasound Clinic

Attn.: Health Records Department

21 Queensway West Suite 110

Mississauga Ontario L5B 1B6

Phone or Text: (905) 897-6970 Fax: (289) 722-2023

Personal Health Records can be picked up in person or mailed to the address provided on the form

**Consent to Access Personal Health Information Pursuant to the Personal Health Information Protection Act,
(PHIPA)**

Section 1: Records to be Accessed

Patient Name _____ Date of Birth (DD/MM/YY) _____ Health Card Number _____

Phone Number _____ Complete Address _____ Postal Code _____

Section 2: Recipient of Records

Patient or Name of Recipient of Records: _____
(i.e custodial parent, doctor's office)

Complete Address _____ Postal Code _____

Phone Number _____ FAX _____

Section 3: Record to be Disclose:

Visit Date _____

- Images
 Report
 Both

Section 4: Choose a Delivery Method:

- In-person Pickup
 E-mail: _____
 Mail (Address from Section-2 will be used. Ensure that section-2 is complete)

Section 5: Signatures*

Patient (16 years and older) _____ Date(dd/mm/yyyy) _____

Custodial Parent/Guardian _____ Relation to Patient _____ Date (dd/mm/yyyy) _____

SDM** _____ Relation to Patient _____ Date (dd/mm/yyyy) _____

** Substitute Decision Maker

Witness Signature _____ Relation to Patient _____ Date (dd/mm/yyyy) _____

*Making a request for access to or correction of personal information under false pretences is an offence under s.61(1)(c) FIPPA / s.48(1)(c) MFIPPA.

For office use only:

Verification identity of individual consenting to access

Patient: Form of Id: Drivers License Passport Health Card other

Parent: Form of Id: Drivers License Passport Health Card other

Validation of SDM: Power of Attorney