Disclosure of Health Information

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Without a patient's permission, CarePoint Health cannot disclose any personal health information to anyone outside of the patient's circle of care. This includes spouses and family members.

Pursuant to the Personal Health Information Act, 2004 (PHIPA), patients are required to fill out the "Consent to Disclose PHI" Form for the purpose of authorizing someone other than the patient to communicate with our staff with regard to the patient's medical information. Once completed, the patient can allow certain individuals to book appointments or pick up forms/test results on their behalf. Patients can fill out the form and either drop it off, email to info@carepointhealth.ca send via Accuro Secure Messaging or traditional mail to our office to complete this process.

Transfer of Records

If patients are requesting a transfer of medical record to another physician or clinic, we require a signed authorization to release the medical record.

Pre-payment of the fee for the transfer of record is required. The charge reflects the cost of materials used, the time required to prepare the material, and the cost of mailing the material to the requesting physician.

The patient may also elect to pick-up copies of the record at our office.

Medical Record Transfer Fees:

$30.00 for the first 20 pages plus $0.25 per additional copies.

We only accept **visa or debit** as form of payment.

Attached:
Consent to Disclose Personal Health Information
Authorization to Transfer Medical Records

July 2020

Consent to Disclose Personal Health Information
Pursuant to the Personal Health Information Protection Act, 2004 (PHIPA)

I, _____ **authorize** _____
(Print your name) *(Print name of health information custodian)*

to disclose

☐ my personal health information consisting of:

_____
(Describe the personal health information to be disclosed)

or

☐ the personal health information of _____
(Name of person for whom you are the substitute decision-maker)*

consisting of:_

_____
(Describe the personal health information to be disclosed)

to _____
(Print name and address of person requiring the information)

I understand the purpose for disclosing this personal health information to the person noted above. I understand that I can refuse to sign this consent form.

My Name:_____ **Address:**_____

Home Tel.:_____**Work Tel.:**_____

Signature:_____**Date:**_____

Witness Name:_____**Address:**_____

Home Tel.:_____**Work Tel.:**_____

Signature:_____**Date:**_____

***Please note: A substitute decision-maker is a person authorized under PHIPA to consent, on behalf of an individual, to disclose personal health information about the individual.**

Authorization to Transfer Medical Records from CarePoint Health (CPH)

1. Regarding Patient *COMPLETE IN FULL (See reverse side for instructions.)*

Name - Last, First, MI		
Street Address		**Telephone # (xxx) xxx-xxxx**
City	**Province**	**Postal Code**
Date of Birth		

2. Records Released From

Name - (e.g. Health Facility, Physician,..)		
Street Address		**Unit #**
City	**Province**	**Postal Code**
Phone # (xxx) xxx-xxxx	**Fax # (xxx) xxx-xxxx**	

3. Records Released To

Name - (e.g. Insurance Co., Lawyer, Physician, Self,...)		
Street Address		**Unit #**
City	**Province**	**Postal Code**
Phone # (xxx) xxx-xxxx	**Fax # (xxx) xxx-xxxx**	

4. INFORMATION TO BE RELEASED: (Check all applicable categories)

☐ **Complete Copy of All Records**

☐ Clinic records pertaining to outpatient treatment of: (Specify approximate date(s) or condition) _____

☐ Other (Specify) _____

FOR THE FOLLOWING DATES: _____

5. PURPOSE OR NEED FOR DISCLOSURE: (Check applicable categories)

☐ Legal Investigation ☐ Personal
☐ Academics ☐ Transfer of Health Care ☐ Other: _____

6. This authorization will remain in effect until this request is processed unless you specify this authorization will be effective for an additional time period. Written consent is necessary to revoke this request.

☐ Additional time period. Specify: _____ ☐ **NONE**
☐ Include future records generated during the additional time period

7. I authorize release of my medical records in accordance with the specification listed above. I understand that I have a right to inspect and receive a copy of the disclosed material. A photocopy of this consent shall be valid as the original. I understand that any costs for this service shall be my responsibility.

8. Signature of patient or authorized representative : **Date:**

ADDITIONAL INFORMATION REGARDING DISCLOSURE OF PATIENT MEDICAL INFORMATION

Revocation. You have the right to revoke this authorization, in writing, at any time before it ends. However, your written revocation will not affect any disclosures of your medical information that the person(s) and/or organization(s) listed on the reverse side of this form have already made, in reliance on this authorization, before the time you revoke it. In addition, if this authorization was obtained for the purpose of insurance coverage, your revocation may not be effective in certain circumstances where the insurer is contesting a claim. Your revocation must be made in writing and addressed to:

CarePoint Health - Suite 120, 2695 North Sheridan Way, Mississauga, ON L5K 2N6

Right to Inspect. You have the right to inspect or copy the medical information whose disclosure you are authorizing.

Copying Fees. There may be a copy fee charge for disclosure and release of medical information as authorized by your signature. The copy charges must be paid before the documentation is released.

Signatures. Generally, if you are 16 years of age or older, you are the only person who is permitted to sign a form to authorize the disclosure of your medical information. If you are under the age of 16, your parent or guardian must sign this form for you. A spouse can not authorize disclosure of medical information for you unless they have legal rights to do so.

This form must form part of your medical record, and any associated charges paid, before the documentation is released.