SAULT AREA HOSPITAL
HÔPITAL DE SAULT-SAINTE-MARIE

iCare

Health Records
Release of Information
Phone: (705) 759-3434 Ext.5336
Fax: (705) 759-3703

AUTHORIZATION FOR ACCESS OR DISCLOSURE OF PERSONAL HEALTH INFORMATION

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

www.sah.on.ca/patients/your-health-records

Patient Name: ______________________________ Date of Birth (dd/mm/yyyy): ___/___/_______
Last Name Given Name

Address: ____
Street City Province/State Post/Zip Code

Telephone: ______________________ Health Card #: ______________________

Release to (Requester Contact Information):

☐ Self ☐ Care Provider ☐ Other: ____________________

Name: ____
Last Name Given Name

Address: ____
Street City Province/State Post/Zip Code

Phone : ____________________

Authorize SAH staff to leave voicemail: ☐ Yes ☐ No Fax: ____________________

Personal Health Information to be Accessed or Disclosed:

Records relating to the following treatment(s): ______________________________

Records within the following timeframe: ______________________________

Additional Description of Information Required (Optional):______________________________

Authorization:

In accordance with PHIPA, authorization must be signed by the patient or the substitute decision maker. If the Person signing is not the patient, state relationship and provide official documentation of authority to do so.

By signing below, the requester understands and agrees to any potential fees that accompany this request for Personal Health Information

______________________________	______________________________
Print: Patient Name/Substitute Decision Maker Name	Print: Name of Witness
______________________________	______________________________
Signature	Signature of Witness
______________________________	______________________________
Date (dd/mm/yyyy)	Date (dd/mm/yyyy)

This authorization will be valid for a 90 day period as of the date of the signature, unless specified otherwise. This authorization may be withdrawn at any time, except with respect to actions already taken before the consent was withdrawn.

For Office Staff Completion:

Photo Identification Shown:	☐ Yes	☐ No
Power of Attorney Received:	☐ Yes	☐ No
Will Received:	☐ Yes	☐ No
Fee Scale Provided:	☐ Yes	☐ No

Office Staff Initials: ____________________