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): ___/___/_____

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

Telephone: _____ Health Card #: _____

Release to (Requester Contact Information):

☐ Self ☐ Care Provider ☐ Other: _____

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): _____

Disclaimer:

Please note, the PCS Archive Report and the Medication Administration Record (MAR) information is not automatically provided in a complete records request unless specifically requested. These documents can be extremely lengthy and create substantial added cost to the requester. If you wish for these documents to be provided please check this box ☐

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: Patient Name/Substitute Decision Maker Name
_____	_____
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 This authorization may be withdrawn at any time, except with respect to actions already taken before the consent was withdrawn.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: _____