CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION

(ce formulaire est aussi disponible en français).

PART 1: PATIENT/CLIENT/RESIDENT INFORMATION

LAST NAME _____ FIRST NAME _____

Date of Birth: D D M M M Y Y Y Y Health Card Number: _____ (9 digit number)

Address: _____
STREET NAME AND NUMBER CITY PROVINCE POSTAL CODE

Phone Numbers: Home: ( ) _____ Work: ( ) _____ Cell: ( ) _____

PART 2: DETAILS OF CONSENT

Consent to _____
NAME/LOCATION OF FACILITY/PROGRAM

disclosing the following personal health information, specifically: _____

To be disclosed to: _____

For the purpose(s) of: _____

This is a consent to disclose my own personal health information: ☐ Yes ☐ No **If NO – complete Part 3.**

PART 3: PERSON PERMITTED TO EXERCISE THE RIGHTS OF AN INDIVIDUAL

LAST NAME _____ FIRST NAME _____

Address: _____
STREET NAME AND NUMBER CITY PROVINCE POSTAL CODE

Phone Numbers: Home: ( ) _____ Work: ( ) _____ Cell: ( ) _____

Indicate Your Authority: _____
You may be required to provide documentation to prove that you have the legal authority to exercise the rights of the individual.

Part 4: SIGN OFF BY PATIENT/CLIENT/RESIDENT OR PERSON PERMITTED TO EXERCISE THE RIGHTS OF AN INDIVIDUAL

- ***I understand that this consent may be withdrawn or amended at any time. A withdrawal does not have a retroactive effect.***
- ***The third party shall not use the personal health information disclosed except for the purpose specified on this consent.***

This consent: ☐ is valid for one year ☐ is valid for this request only ☐ expires on _____
D D M M M Y Y Y Y

Signature of Person Consenting: _____ Date: _____
D D M M M Y Y Y Y

Part 5: OTHER

Signature of Privacy Officer/Advisor: _____ Client ID/Health Record #: _____

Date Received: _____

Guideline for Completing the "Consent to Disclose Personal Health Information Form (PHI)"

The Personal Health Information Act (PHIA) permits trustee's to use PHI without the consent of individual or a person permitted to exercise the rights of an individual, under specific circumstances. This form is to be used **only** when a trustee is required to disclose PHI for a purpose that requires consent from the individual or a person permitted to exercise the rights of an individual.

Part 1: Consent from Patient/Client/Resident.

- Record the last name, first name, date of birth, health card number (the 9 digit PHIN in Manitoba or another jurisdictions health card number), address (in full) and phone numbers of the individual the information is about.

Part 2: Details of Consent

- Indicate the name of the hospital, personal care home, clinic, community health centre, and/or program disclosing the PHI such as midwifery, home care, public health, mental health etc.
- Specify the PHI that is to be disclosed.
- Specify to whom the PHI will be disclosed.
- Indicate if the request is for the individual's own PHI, if so check "yes", if not check "no" and complete Part 2.

Part 3: Person Permitted to Exercise the Rights of an Individual

- Record the last name, first name, complete address and phone numbers of the person permitted to exercise the rights of an individual the information is about.
- Indicate the authority of the person permitted to exercise the rights of the individual from the following list.

  (a) any person with written authorization from the individual to act on the individual's behalf;
  (b) a proxy appointed by the individual under The Health Care Directives Act;
  (c) a committee appointed for the individual under The Mental Health Act if the committee has the power to make health care decisions on the individual's behalf;
  (d) a substitute decision maker for personal care appointed for the individual under The Vulnerable Persons Living with a mental Disability Act if the exercise of the right relates to the powers and duties of the substitute decision maker;
  (e) the parent or guardian of an individual who is a minor, if the minor does not have the capacity to make health care decisions;
  (f) if the individual is deceased, his or her Personal Representative.

  If it is reasonable to believe that no person listed in any clause above exists or is available, the adult person listed first in the following clauses who is readily available and willing to act may exercise the rights of an individual who lacks the capacity to do so:

  (a) the individual's spouse, or common-law partner, with whom the individual is cohabitating
  (b) a son or daughter
  (c) a parent, if the individual is an adult;
  (d) a brother or sister;
  (e) a person with whom the individual is know to have a close personal relationship;
  (f) a grandparent;
  (g) a grandchild;
  (h) an aunt or uncle;
  (i) a nephew or niece.

  Ranking: The older or oldest of two or more relatives described in any clause of the above is to be preferred to another of those relatives.

Part 4: Sign Off

- Indicate if the request is valid for one year, is valid for this request only or has an expiration date by placing a check mark in the appropriate box. If the consent has an expiration date, specify the date.
- Signature of the patient/client/resident or person permitted to exercise the rights of the individual (as described in Parts 1 or 3).
- Record the date consent is obtained.

Part 5: Other

- Signature of Privacy Officer/Designate.
- Record the date the request was received and the Client ID/Health Record #.
- File the completed Consent to Disclose PHI form on the patient's/client's/resident's health record.

Reference: ORG.1411.PL.502 Use and Disclosure of Personal Health Information