Consent to Disclose Personal Health Information

Pursuant to the Personal Health Information Protection Act, 2004 (PHIPA) and the Personal Information Protection and Electronic Documents Act (PIPEDA)

Personal Information:

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Other

Surname: _____ **Given Name:** _____ **Initial:** _____

Date of Birth: _____ **Health Card #:** _____
Month / Day / Year

Address: _____ **Unit #** _____

City: _____ **Province:** _____ **Postal Code:** _____

Telephone: _____ **Cell #:** _____

Substitute Decision-Maker Information: *

Surname: _____ **Given Name:** _____ **Initial:** _____

Address: _____ **Unit #** _____

City: _____ **Province:** _____ **Postal Code:** _____

Telephone: _____ **Cell #:** _____

*Please provide documentation to satisfy the health information custodian that you are an authorized substitute decision-maker, if available.

Please provide a detailed description of the personal health information you are requesting, and any details that will assist in locating this information (e.g., dates, name of health care provider, etc.).

Preferred method of access to records: ☐ Examine Original ☐ Receive a Copy

I will be notified in writing within 30 days of the Canadian Mental Health Association Cochrane-Timiskaming Branch's receipt of this request whether my request has been granted or not.

If my request is granted, I understand that:

1. The original records cannot be removed from the premises of the CMHA Cochrane-Timiskaming Branch.
2. There may be a fee associated with compiling my clinical records.
3. If there are concerns with the contents of my file that are likely to cause serious harm to my treatment or recovery process or serious harm to another person, the CMHA Cochrane-Timiskaming Branch may consult with my referral source and/or my physician.
4. Information may be redacted to protect the privacy and confidentiality of other individuals.

I am requesting access to my clinical records within the Canadian Mental Health Association Cochrane-Timiskaming Branch from

_____ to _____
Month / Day / Year (start date) Month / Day / Year (end date)

My clinical records are to be released to (Self, Hospital, Health Care Provider, Lawyer, etc):

Name of Recipient: _____

Street Address: _____ **City:** _____

Province: _____ **Postal Code:** _____ **Fax #:** _____

If the files are to be released to more than one recipient, a second form is to be completed.

_____ _____
Client Signature **Date (Month / Day / Year)**

_____ _____
Witness Signature **Date (Month / Day / Year)**

For Health Information Custodian Use Only					
Notification of Request Received:		**CMHA Consent Form Received:**		**Extension Requested:**	
Date Release package completed and sent to recipient(s) and Privacy Officer:					

The personal health information contained on this form is collected pursuant to the *Personal Health Information Protection Act, 2004 (*"the *Act")* and will be used for the purpose of responding to your request for access pursuant to section 54 of the *Act.* Questions about this collection should be directed to the Privacy Officer at the Canadian Mental Health Association Cochrane-Timiskaming Branch.