**HOME AND COMMUNITY CARE SUPPORT SERVICES** | **SERVICES DE SOUTIEN À DOMICILE ET EN MILIEU COMMUNAUTAIRE**

# REQUEST/CONSENT FOR RELEASE OF PERSONAL HEALTH INFORMATION

*under the Personal Health Information Protection Act, 2004*

## Organization to whom the request is being made

Select Home and Community Care Support Services geography from list below:

Submit your request to the address or fax number above. *Note: Legislation permits a 30-day response time.*

## Patient whose information is being requested

Last Name: | Health Card Number:

First Name: | Date of Birth (DD/MM/YYYY):

## Information about the person making the request

Last Name:

First name:

Contact #:

Mailing Address:

- ☐ Patient
- ☐ Substitute Decision Maker
  - Relationship to patient:
- ☐ Other (specify):

## Records being requested

☐ All health records for a specific time frame

From: ____ ____ ____ (DD MM YYYY) To: ____ ____ ____ (DD MM YYYY)

☐ Specific record(s), as outlined below:

Reason for request (optional):

- ☐ Personal
- ☐ Support care planning
- ☐ Legal
- ☐ Insurance form/claim
- ☐ Estate
- ☐ Tax exemption
- ☐ Other (specify):

## Special instructions

**Method/format of release:**

- ☐ Electronic copy – Email address:
- ☐ Paper copy to address above
- ☐ Paper copy to alternate person and/or address (specify):
  - Name: Mailing address:
- ☐ Other (specify):

**Is this release time sensitive?** ☐ No ☐ Yes (specify):

**Accommodations required?** ☐ No ☐ Yes (specify):

Print Name | Signature | Date (DD/MM/YYYY)

*The information on this form is collected pursuant to the Personal Health Information Protection Act, 2004 ("the Act"). The information will be used for the purposes of identifying the patient and responding to the request for access pursuant to section 54 of the Act. Questions about this collection should be directed to the Privacy or Health Records contact person at the organization where the request for access is made.*