STEVENSON MEMORIAL HOSPITAL

200 Fletcher Crescent
Alliston, Ontario L9R 1W7
Fax: 705-434-5120
Phone: 705-435-6281 Extension 1216

Chart #:
Account #:

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION

I Hereby Authorize: _____

(NAME OF PERSON/FACILITY RELEASING INFORMATION)

To Release to: _____

(Name and Address of Person Receiving Information - e.g. Doctor/Lawyer/ Insurance Co./Self) _____

_____

_____

Type of Information Required: ❑ MEDICAL IMAGING (CD/FILMS) ❑ COPIES OF MEDICAL RECORDS

Will information be Picked up in Person: ❑ YES ❑ NO

Dates of Treatment: Or Medical Imaging: _____

_____

_____

_____

Patient's Name (PRINT): _____ _____

Last Name First Name

Patient's Address _____

_____

Patient's Date of Birth: _____/_____/_____ dd/mm/yy **OHIP #:** _____

Patient's Daytime Telephone Number(s): _____

Signature of Patient or Authorized Representative: _____ **Date:** _____/_____/_____ dd/mm/yy

Relationship to the Patient: _____ **Date:** _____/_____/_____ dd/mm/yy

(If not the patient)

Signature of Witness: _____ **Date:** _____/_____/_____ dd/mm/yy

Print Name of Witness: _____

Print

Reset

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Notes:

1. This authorization is valid for a period of ***90 days from the date of signing*** and may be rescinded or amended in writing during that period except where action has been taken based on authorization provided;
2. This authorization must contain:
   a. The *signature* of the patient (capable individual who is 14 years or older to whom the record pertains); or
   b. The *signature* of a person who is authorized by the patient to receive the information on the patient's behalf,
      i. **accompanied by a letter consenting to this release signed by the patient***; or*
   c. The signature of the patient's legal representative if the patient is deceased or has been certified mentally incompetent.
   d. The signature of the witness to the patient's or authorized representative's signature
3. This authorization shall apply only to information dated prior to date of signature;
4. If the patient does not read or understand English, the authorization form must be interpreted for the patient. The person who acts as the *interpreter must* sign the form as a *witness* to confirm that this has been done.

Faxed ***Authorization to Release Personal Health Information forms/requests for direct fulfillment to the individual to whom the information pertains are accepted,*** however two valid pieces of government issued identification, one of which must be a photo ID, will be required for identity verification before delivery of required information to the individual. Persons without a driver's license or passport may provide one valid piece of government issued identification, e.g. OHIP card.

REQUIRED FEES

Copies of Medical Records: **Non-refundable search fee of $30.00 (includes first 20 pages) +HST is required to initiate the processing of request, plus $0.25 per additional page payable upon completion of request.**

Medical Imaging/CD Films: $12.00 per Medical Imaging CD is applicable

Guide to Requesting your Personal Health Information from Stevenson Memorial Hospital

To request a copy of your personal health information, you must provide the following:

- A completed and signed Consent to Release Personal Health Information
- The administrative fee (see REQUIRED FEES)

Requests are processed when the above required information is received in good order. They are processed in order of receipt. We are required to respond within 30 days.

Release of Information will contact you when the records are ready for pick up and inform you of the balance owing (if applicable).
If you are requesting copies of diagnositic images such as X-rays, ultrasounds or CT Scans (in disc format) we will require 24 hours to process and a credit card number to process the request.

For urgent requests for medical records, we do offer a rush service at an additional fee of $300.00 and must be provided before processing. Urgent requests can be ready within 48 hours during business hours.

If you are making a request for records of a deceased patient, the executor(s) information must be completed and signed by all the executors. Proof of executor authority and a copy of the will is required.

If you have any questions, please contact Release of Information at 705-435-3377 Ext 1216

PICKED UP BY:_____

(please print clearly)

_____ **Date:** _____/_____/_____

Signature of Patient/Guardian/Delegate dd/mm/yy

_____ **Date:** _____/_____/_____

Witness dd/mm/yy

ID Verified: ☐ Yes ☐ No **ID Verified by:** *(Print first, last)*_____

FOR OFFICE USE ONLY			
Total Amount: $_____	VISA/MasterCard #:_____	CVC:_____	Expiry: _____/_____

Print

Reset