CONSENT TO RELEASE PERSONAL HEALTH INFORMATION

I, ____, authorize the District of Timiskaming Social
(Print Name)
Services Administration Board (DTSSAB), to disclose:

☐ my personal health information (PHI) consisting of:

____

____
(Describe the personal health information to be disclosed)

or

☐ the personal health information of ____
(Name of person for whom you are the substitute decision-maker)*

consisting of:

____

____
(Describe the personal health information to be disclosed)

to ____
(Print name and address of person requiring the information)

What is your relationship to the person for whom you are requesting this information:

____

I understand that this personal health information is to be used only by the recipient for the purposes of:

____

____

Expiry Date of This Consent (optional): ________________________________

I understand the purpose for disclosing this personal health information to the person noted above. I understand that I can refuse to sign this consent form.

My Name: __________________________ Address: __________________________

Home Phone: ________________________ Work Phone: ________________________

Signature: __________________________ Date: __________________________
(YY/MM/DD)

Witness Name: ______________________ Address: __________________________

Home Phone: ________________________ Work Phone: ________________________

Signature: __________________________ Date: __________________________
(YY/MM/DD)

***Please note: A substitute decision-maker is a person authorized under PHIPA to consent, on behalf of an individual, to disclose personal health information about the individual.**

Request Approved By: ______________________________ Date: ______________________
(Emergency Medical Services Deputy Chief/Chief) (YY/MM/DD)

______________________________ Date: ______________________
(Chief Privacy Officer) (YY/MM/DD)

Tracking Number Assigned: __________________________

Date Request Received By EMS Program: ____________________________________

Date Request Received By Corporate Access & Privacy Office: ___________________
(YY/MM/DD)

Date Request Processed: ___________________________ By: ________________________
(YY/MM/DD)

Date PHI Provided to Requestor: ______________________ By: ________________________
(YY/MM/DD)

Time to Completion (Days): ____

Disposition of Request

- ☐ All information disclosed
- ☐ Disclosed in part – provisions applied to deny access
- ☐ Nothing disclosed – provisions applied to deny access
- ☐ Disclosed in part – no records exist or cannot be found
- ☐ Nothing disclosed – no records or cannot be found
- ☐ Disclosed in part – outside PHIPA

Fees

- ☐ Application Fee Collected ____
- ☐ Processing Fee(s) Collected ____
- ☐ Fee(s) Waived In Part ____
- ☐ Fee(s) Waived In Full ____

Distribution

Original – Corporate Access & Privacy Office

Copy – Emergency Medical Services Chief

Check Off Attachments to This Request

- ☐ Detailed list of PHI disclosed/not disclosed
- ☐ Copy of receipt issued
- ☐ Other ______________________________