# Authorization for Release of Personal Health Information

Renfrew Victoria Hospital
499 Raglan St N Renfrew, On K7V 1P9
Phone: 613-432-4851 ext. 804 Fax: 613-433-5722

## PART 1: PATIENT INFORMATION

| Last Name | First Name | Alias |
|---|---|---|
| | | |

| Address | City/Province | Postal Code |
|---|---|---|
| | | |

| Phone Number | Date of Birth (DD/MM/YYYY) | OHIP # (or other insurance #) |
|---|---|---|
| | | |

## PART 2: PERSON RECEIVING RECORDS

| ☐ Myself **or** ☐ Name of person receiving the records | Relation to Patient | Name of Company or organization (if applicable) |
|---|---|---|
| | | |

| Mailing Address | City/Province | Postal Code |
|---|---|---|
| | | |

| Phone Number | Fax Number (if applicable) | Records to be: |
|---|---|---|
| | | ☐ Picked up ☐ Mailed ☐ Faxed ☐ Sent Electronically |

## PART 3: RECORDS REQUESTED

| Information | Comments and Dates |
|---|---|
| ☐ Discharge Summary | |
| ☐ Operative Reports | |
| ☐ Pathology Reports | |
| ☐ Anesthesia/Recovery Room | |
| ☐ Medical Imaging ☐ report ☐ images | |
| ☐ Laboratory Reports | |
| ☐ Consultation/Progress Notes | |
| ☐ ER Record | |
| ☐ Summary of Chart* | |
| ☐ Confirmation of Dates | |
| ☐ Proof of Death (Discharge Summary) | |
| ☐ Other | |

*Can include but not limited to discharge summary, operative and pathology reports, consultation reports, medical imaging, and laboratory reports.

## PART 4: PURPOSE FOR DISCLOSURE

## PART 5: PATIENT AUTHORIZATION

**I authorize the Renfrew Victoria Hospital to release the records requested to the above recipient (Part 2).**

| Signature of Patient or Representative | Date (DD/MM/YYYY) |
|---|---|
| | |

| Witness Name and signature | Date (DD/MM/YYYY) |
|---|---|
| | |

Disclaimer: Renfrew Victoria Hospital (RVH) policy is to send/receive documentation by fax or mail. If you wish us to send/receive documentation via email, please be advised that we cannot ensure the privacy or confidentiality of the contents. RVH will not be liable for any breach of confidentiality that may occur by the files being emailed to or from you at your request.

I have read/understand the above disclaimer (initial) _____

Photo ID Verified:_____

**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 This authorization is valid for a period of 90 days from the date of signing and may be rescinded or amended in writing during that period except where action has been taken based on authorization provided.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 16 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, 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. (Provide Proof)
    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. **All forms must be accompanied by a copy of Photo ID**.

**REQUIRED FEES:**

| Request for | Fee (+13% HST) | Fee per page |
|---|---|---|
| **Charges for copies** | $30.00<br>$40.00 (CD/USB)<br>$30.00 (electronic) | + .25¢ per copy (>20)<br>N/A for CD<br>N/A for Electronic |
| **Confirmation of Visit** | $10.00 | N/A |
| **Physicians for ongoing patient care** | No charge | N/A |