Capital Health

Access to Personal Health Information / Legal Services

Authorization for Release of Personal Health Information

Please drop off, fax or mail your form to: **Access to Personal Health Information**
QEII, Halifax Infirmary Site, Room 1123 - 1796 Summer Street, Halifax, NS B3H 3A7
Tel: 473-5512, Fax: 473-2091
(**Please Note**: Charges apply for copying records and processing requests)

Please indicate here which records you are seeking to access:

☐ All Capital Health Records for all facilities; **OR**

☐ Cobequid Community Health Centre
☐ Eastern Shore Memorial Hospital
☐ Nova Scotia Hospital
☐ QEII Health Sciences Centre
☐ Dartmouth General Hospital
☐ Hants Community Hospital
☐ Public Health
☐ Integrated Chronic Care Service
☐ East Coast Forensic Hospital
☐ Musquodoboit Valley Memorial Hospital
☐ Twin Oaks Memorial Hospital
☐ Specify facility, program or service _____

1. IDENTIFICATION INFORMATION: Please complete this section with information relating to the person whose records are being disclosed. (Please print clearly and provide as much information as possible in this section. If the information is not complete, we may not be able to identify the person and complete your request).

_____ _____ _____
Last Name First/Given Name Middle Initial

_____ Date of Birth: _____
Previous Surname (if applicable) (Year/Month/Day)

_____ _____
Provincial Health Card number Mailing Address (Street # / Unit # / Apartment #)

_____
Mailing Address (City, Province, Postal Code)

Daytime Telephone number _____ Check if person is deceased ☐

2. RELEASE TO: Check each that applies

☐ I am requesting access to my own record **OR**
☐ I am authorizing release of information to the following person(s):

_____
Name of Person/Organization to Receive the Information requested

_____
Mailing Address (Street #/ Unit #/ Apartment #)

_____
Mailing Address (City, Province, Postal Code)

Telephone Number (_____) _____ Fax (_____) _____

I authorize this release to include:
☐ Capital Health staff and physicians discussing verbally my personal health information.

3. Length of Time for which Release is Valid – CHECK ONE

☐ I understand that unless otherwise indicated below, this Authorization will expire one (1) year after the date it was signed **OR**

I am indicating that I want this authorization to expire as indicated below (check one):

- ☐ Authorization expires immediately upon completion of the requested release
- ☐ Authorization expires on (indicate specific date): _____

4. My Authorization for Release is Limited to the following:

☐ Whole record * **OR**

- ☐ All records * from the time period (year/month/day) _____ to _____
- ☐ Visit History
- ☐ The following specific records _____ from (year/month/day) _____ to _____
- ☐ Cancer Centre Records
- ☐ Diagnostic Images on CD
- ☐ Series Visits/Outpatient Visits

* **Does not include** financial records, Addiction Prevention and Treatment Services records (call 424-7257), but **does include** all Mental Health records if the whole record is requested.

5. My Authorization for Release is for the following: - CHECK ONE ONLY

☐ View only **OR** ☐ Photocopies (**Fees may be payable in advance**)

6. SIGNATURES (required for all requests – please use ink)

I give permission to Capital Health to release my personal health information as indicated in this form. This form will authorize the release of my personal health information gathered prior to the date of signature, **as well as information gathered up to one year after the date of signature unless I have otherwise indicated in Box #3**. I may withdraw my permission at any time, in writing, as long as the information has not already been released. I hereby release Capital District Health Authority and its employees and agents from any and all claims whatsoever which may arise as a result of the release of my personal health information. I agree that I am personally responsible to pay any fees associated with the release.

Patient Signature _____ Date _____

OR

Substitute Decision Maker *

Signature _____ Date _____

* Must Complete a Capital Health Declaration of Substitute Decision Maker for Release of Information Form (**CD1586MR**) – please contact APHI staff at 473-5512 if you require this form.

FOR ACCESS TO PERSONAL HEALTH INFORMATION STAFF USE ONLY

Date Requested received: _____ Staff Releasing Info: _____

Information Released and Notes: _____