NORTHERN HEALTH REGION

Guideline for Verification of a Completed Personal Health Information Request Form

Appendix A

This document is a quick reference to ensure the Personal Health Information Request form is completed accurately. However, it should only be referenced in conjunction with the Reporting and Disclosure of Information to Child and Family Services policy (AD-07-105)

Section 1: Collection Authority

This section sets out the legislatively supported purposes for which a CFS Agency/Worker would have authority to collect personal health information.

Verify:

- The collection authority is checked

SECTION 1: COLLECTION AUTHORITY – This form is a onetime request for personal health information for the purpose of:	
☐	Conducting a child protection investigation pursuant to Subsection 18.4(1) of *The Child and Family Services Act.*
☐	Providing child protection services pursuant to Subsection 18.4(1) of *The Child and Family Services Act.*
☐	Caring for a child under apprehension pursuant to Section 25 of *The Child and Family Services Act.*
☐	Fulfilling responsibilities as temporary or permanent guardian as per an order from *The Court of Queen's Bench.*
☐	Notifying an individual of a hearing pursuant to Subsection 20(2), 25(4) or 30(1) of *The Child and Family Services Act.*
☐	Other: _____ ***(Please contact Manitoba Health directly at (204) 788-6612 to verify this authority)***

Section 2: Facility/Program Information

The CFS Agency/Worker must identify what facility and/or program that they believe maintains the personal health information that they are seeking, as well as the specific health care practitioner if known.

Verify:

- The name of the facility and/or program are listed
- The name of the health care practitioner is listed where available

SECTION 2: TRUSTEE INFORMATION – What trustee is the information being requested from?	
Name of Branch/Facility/Program:	Health Practitioner Name (if known):

Section 3: CFS Contact Info

The CFS Agency/Worker must complete all the information in this section prior to disclosure of the personal health information unless the information is required in an urgent situation.

Verify:

- The specific Authority and CFS Agency and its full address are recorded.
- The name of the CFS Worker that is seeking the information and who is familiar with the case.
- The phone number for the above noted CFS Worker.
- The fax number for those cases where it has been determined that faxing is the most appropriate method of providing the information.
- The date of the request and the signature of the CFS worker must be included.

SECTION 3: CHILD AND FAMILY SERVICES CONTACT INFORMATION		
Authority: ☐ General ☐ First Nations of Northern MB ☐ First Nations of Southern MB ☐ Métis		
CFS Agency:	CFS Worker:	
Phone:	Fax:	
Address:	City/Town:	Postal Code:
Signature:	Date of Request:	

Section 4: Timeframe for Providing Info

The CFS Agency/Worker should indicate the time frame for obtaining the information.

Verify:

- "Immediately" option is **only** checked if the information is urgently required.
- A time frame has been selected.
- Note: time frame begins upon receipt of the completed form.

SECTION 4: TIMEFRAME FOR PROVIDING INFORMATION		
☐ IMMEDIATELY	☐ WITHIN 2 WEEKS	☐ WITHIN 30 DAYS

Section 5: Information is Being Sought on the Following Individuals

CFS can request information on any individual that is permanently or temporarily in the same premise as a child that may be in need of protection.

Verify:

- Adequate information has been provided to positively identify the individual(s).

SECTION 5: INFORMATION IS BEING SOUGHT ON THE FOLLOWING INDIVIDUAL(S) CHECKED BELOW:				
☐	Mother's Last Name:		First:	Middle:
	PHIN:		Registration No.:	D.O.B.:
	Address:		City/Town:	Postal Code:
☐	Father's Last Name:		First:	Middle:
	PHIN:		Registration No.:	D.O.B.:
	Address:		City/Town:	Postal Code:
☐	Other Person - Last Name:		First:	
	☐ M ☐ F	PHIN:	Registration No.:	D.O.B.:
	Address:		City/Town:	Postal Code:

☐	Child 1 Last Name:		First:	☐ in care ☐ not in care
	☐ M ☐ F	PHIN:	Registration No.:	D.O.B.:
☐	Child 2 Last Name:		First:	☐ in care ☐ not in care
	☐ M ☐ F	PHIN:	Registration No.:	D.O.B.:
☐	Child 3 Last Name:		First:	☐ in care ☐ not in care
	☐ M ☐ F	PHIN:	Registration No.:	D.O.B.:
☐	Child 4 Last Name:		First:	☐ in care ☐ not in care
	☐ M ☐ F	PHIN:	Registration No.:	D.O.B.:

Section 6: PHI Being Requested

The CFS Agency/Worker is required to list what information they are requesting as specifically as possible, including, but not limited to:

- the nature of any injuries or treatment provided to a child on a specific date or within a specified time frame;
- the medical conditions of a child in care (e.g. allergies);
- what was the date and reason for the last doctor/hospital visit; or
- the last known mailing address.

Verify:

- The information requested is listed in this section

SECTION 6: PERSONAL HEALTH INFORMATION BEING REQUESTED
List the ***specific*** information being requested (include dates if possible):

Section 7: Disclosing Trustee's Information

This section must be completed by the Northern Health Region employee who is releasing the requested information.

Verify:

- Disclosing employee, position, phone, signature, and date are completed.
- Method of disclosure is checked.
- Reason for partial or non-disclosure is recorded.
- A list of what information was disclosed is attached or recorded in the client's health record.

SECTION 7: DISCLOSING TRUSTEE'S INFORMATION			
Disclosing Employee:			Phone:
Position:			Fax:
☐	Requested information provided.	☐ By phone: HARDCOPY FOLLOW-UP REQUIRED ☐ By mail ☐ By courier ☐ By fax ☐ Pickup by authorized person	
☐	Requested information provided ***in part***.	Explanation:	
☐	Requested information ***not*** provided.	Explanation:	
Signature:		Date:	