NORTHERN HEALTH REGION

Consent to Disclose Personal Health Information

Part 1 Client Information

Last Name _____ First Name _____

Date of Birth _____ (DD/MMM/YYYY) Health Card # _____ (9 digit number)

Address _____
Street Name and Number City Province Postal Code

Home Phone _____ Work Phone _____ Cell Phone _____

Part 2 Details of Consent

_____ may disclose the following personal health information, specifically:
Name, Location of Facility, Program

To be disclosed to _____
Name, Location of Facility, Program Mailing Address

For the purpose(s) of _____

This is a consent to disclose my own personal health information ☐ Yes ☐ No **If No - complete Part 3**

Part 3 Alternate Decision Maker (ADM)

Last Name _____ First Name _____

Address _____
Street Name and Number City Province Postal Code

Home Phone _____ Work Phone _____ Cell Phone _____

Indicate your authority to act on behalf of the individual _____

You may be required to provide documentation to prove you have the legal authority to exercise the rights of the individual.

Part 4 Sign-off by Client or ADM

- I understand that this consent may be withdrawn or amended at any time. A withdrawal does not have a retroactive effect.
- The third party cannot use the personal health information disclosed except for the purpose specified on this consent.

This consent ☐ is valid for one (1) year ☐ is valid for this request only expires on _____ (DD/MMM/YYYY)

_____ Date _____
Signature of Person Consenting (DD/MMM/YYYY)

NORTHERN HEALTH REGION

Consent to Disclose Personal Health Information

Guideline for Completing the "Consent to Disclose Personal Health Information Form (PHI)"

The Personal Health Information Act (PHIA) permits trustee's to use PHI without the consent of individual or a person permitted to exercise the rights of an individual, under specific circumstances. This form is to be used **only** when a trustee is required to disclose PHI for a purpose that requires consent from the individual or a person permitted to exercise the rights of an individual.

Part 1: Consent from the Client

- Record the last name, first name, date of birth, health card number (the 9 digit PHIN in Manitoba or another jurisdictions health card number), address (in full) and telephone numbers of the individual the information is about.

Part 2: Details of Consent

- Indicate the name of the hospital, personal care home, clinic, community health centre, and/or program such as midwifery, home care, public health, mental health etc. that is requesting to use the PHI.
- Specify the PHI that is to be disclosed.
- Specify to whom the PHI will be disclosed.
- Indicate if the request is for the individual's own PHI, if so check "yes", if not check "no" and complete Part 2.

Part 3: Alternate Decision Maker (ADM)

- Record the last name, first name, complete address and phone numbers of the person permitted to exercise the rights of an individual the information is about.
- Indicate the authority to request a correction to the PHI from the following list:

a) Any person with written authorization from the individual to act on the individual's behalf;
b) A proxy appointed by the individual; under The Health Care Directives Act;
c) A committee appointed for the individual under The Mental Health Act if the committee has the power to make health care decisions on the individual's behalf;
d) A substitute decision maker for personal care appointed for the individual under *The Vulnerable Persons Living with a Mental Disability Act* if the exercise of the right relates to the powers and duties of the substitute decision maker;
e) by an attorney acting under a power of attorney granted by the individual, if the exercise of the right or power relates to the powers and duties conferred by the power or attorney;
f) The parent or guardian of an individual who is a minor, if the minor does not have the capacity to make health care decisions;
g) If the individual is deceases, their Personal Representative.

If it is reasonable to believe that no person listed in any clause above exists or is available, the adult person listed first in the following clauses that is readily available and willing to act *may* exercise the rights of an individual who lacks the capacity to do so:

(a) The individual's spouse, or common-law partner, with whom the individual is cohabitating;
(b) A son or daughter;
(c) A parent, if the individual is an adult;
(d) A brother or sister;
(e) A person with whom the individual is known to have a close personal relationship;
(f) A grandparent;
(g) A grandchild;
(h) An aunt or uncle;
(i) A niece or nephew.

Part 4: Sign Off

- Indicate if the request is valid for 1 year, is valid for this request only or has an expiration date by placing a check mark in the appropriate box. If the consent has an expiration date, specify the date.
- Signature of the patient/client/resident or person permitted to exercise the rights of the individual (as described in Parts 1 or 3).
- Record the date consent is obtained.
- File the completed Consent to Disclose PHI From on the patient's/client's/resident's health record.