



Consent for Release/Request of Personal Health Information (Submission instructions on reverse)

This request will be retained as part of the Health Record

NL Health
Services

IDENTIFICATION:

Name: _____ Health Care Number: _____

Date of Birth: DD/MM/YYYY Mother's First Name: _____

Maiden Name: _____ If deceased, date of death: DD/MM/YYYY

COMPLETE SECTION A or B AS APPLICABLE

A. INFORMATION REQUEST: ONGOING CARE and SERVICE BY TREATING HEALTHCARE PROVIDERS

Name of Healthcare Provider/Program: _____

Mailing Address: _____ City/ Province: _____ Postal Code: _____

Name and telephone of contact person: _____

This is an URGENT REQUEST required for care today

B. PERSONAL OR THIRD PARTY REQUESTS (See back for detailed explanation)

I hereby authorize NL Health Services Release Request Personal Health information to from: _____

Select the Zone for the medical records you are requesting: Eastern Western Central Lab-Grenfell

Name: _____

Mailing Address: _____ City/ Province: _____ Postal Code: _____

Name and telephone of contact person: _____ Purpose of request: _____

INFORMATION DESCRIPTION

diagnostic imaging reports visit history laboratory reports birth records complete chart

operative and pathology reports autopsy report If yes, location: _____

other, specify: _____

Limited Access or Restriction Instructions, (specify): _____

Time frame: Date: DD/MM/YYYY to Date: DD/MM/YYYY

PERMISSION AND SIGNATURE

This authorization will expire in _____ days, and must be submitted to NLHS within 90 days of dated signature.
This authorization may be revoked in writing at any time prior to the expiration date, except where action has already been taken.

Date: DD/MM/YYYY Signature: _____

Original signature of patient/client/resident or authorized representative with supporting documents.

DELIVERY OF INFORMATION

Information will be mailed via Canada Post unless requestor makes arrangements for pick up in person.
In emergent or urgent situations, faxing or emailing of information is available:

Faxed to the number provided below**. E-mailed to address provided below**

** Sending personal health information by fax or email carries a potential risk of improper or inadvertent disclosure.

Print fax number or e-mail address: _____

Signature: _____ Date: DD/MM/YYYY

For Office Use Only

Processed by: Name: _____ Signature: _____

Date: DD/MM/YYYY Program/Department: _____

Send completed forms to: ROI@nlhealthservices.ca



Requests for personal health information must be made in writing.

All patient/resident/client's must complete Identification. Prior to the release of information, the patient/resident/client must be positively identified. It is the responsibility of the Release of Information staff or agent designated to release information to verify at least 3 identifiers approved by NL Health Services.

- Name
- MCP/Unit Number/Health Care Number
- Photo ID
- Date of Birth
- Mother's Name

Information will be mailed to the patient/resident/client's address as recorded on registration or picked up in person. When arriving in person, a photo or two other pieces of ID will be required.

Section A: While in the course of treatment and or service, a custodian, healthcare provider either within or outside the Province, may have access to a patient/resident/client's Personal Health Information, without written consent. The preferred method of releasing information is by mail/email. Information may only be faxed when required for **Immediate** or **Urgent** care.

Section B: Requests can be broken into 2 different types: Third Party and Personal Requests

Third Party Requests:

Personal health information may be released/disclosed by authorized NL Health Services staff or agents with the original signed consent of the patient/resident/client, or authorized representative, or when required or permitted by Law.

Personal Requests:

Upon written request NL Health Services will allow access or provide copies of personal health information to a patient/resident/client or authorized representative about themselves or their minor children. Release of information will not be denied except in circumstances described and defined by the Personal Health Information Act.

Third parties are individuals other than the patient/resident/client and those involved in the circle of care. Third parties include but are not limited to:

- Lawyers
- Insurance Companies
- Member of the House of Assembly
- Family
- Employer
- Schools
- Parents and Guardians
- Power of Attorney

Applicable charges will be applied to requests according to NL Health Services fee schedule. A copy is available.

INFORMATION DESCRIPTION: give detailed description of the information to be released, when possible include site/program/service/department and period of when the information was collected.

Patient/resident/client have the right to limit the amount of information they wish to release. To limit access, the patient/resident/client must, provide instruction or describe the information that may not be released.

FAXING AND E-MAIL RISKS:

Faxing and e-mailing have security weaknesses. To safeguard against improper or inadvertent access NL Health Services has created policies to govern this method of information exchange or disclosure.