

## Consent to Disclose Personal Health Information

### PART 1: PATIENT/CLIENT/RESIDENT INFORMATION

Last Name: _____	First Name: _____		
Date of Birth: _____ (yyyy/mm/dd)	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: PERSON PERMITTED TO EXERCISE THE RIGHTS OF AN INDIVIDUAL

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: _____			
<i>You may be required to provide documentation to prove you have the legal authority to exercise the rights of the individual.</i>			

### PART 4: SIGN OFF BY PATIENT/CLIENT/RESIDENT OR PERSON PERMITTED TO EXERCISE THE RIGHTS OF AN INDIVIDUAL

- I understand that this consent may be withdrawn or amended at any time.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

This consent                      is valid for 1 year                      is valid for this request only                      expires on: \_\_\_\_\_  
(yyyy/mm/dd)

Signature of Person Consenting \_\_\_\_\_                      Date: \_\_\_\_\_  
(yyyy/mm/dd)



## 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 Patient/Client/Resident

- 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 phone 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: Person Permitted to Exercise the Rights of an Individual

- 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 your authority to exercise the rights of the individual from the following list.
  - any person with written authorization from the individual to act on the individual's behalf;
  - a proxy appointed by the individual under The Health Care Directives Act;
  - 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;
  - a substitute decision make 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 make;
  - the parent or guardian of an individual who is a minor, if the minor does not have the capacity to make health care decisions;
  - if the individual is deceased, his or her 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 who 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 | (f) a grandparent;     |
| (b) a son or daughter  | (g) a grandchild;      |
| (c) a parent, if the individual is an adult;   | (h) an aunt or uncle;  |
| (d) a brother or sister;   | (i) a nephew or niece. |
| (e) a person with whom the individual is know to have a close personal relationship;         |                        |

Ranking: The older or oldest of two or more relatives described in any clause of the above is to be preferred to another of those relatives.

### 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.