

Consent to Use Personal Health Information

PART 1 Client Information			
Last Name	_____	First Name	_____
Date of Birth	_____	Health Card #	_____
	(DD/MMM/YYYY)	(9 digit number)	
Address	_____		
	Street Name and Number	City	Province Postal Code
Home Phone	_____	Work Phone	_____ Cell Phone _____

PART 2 Details of Consent	
_____	may use the following personal health information, specifically
Name/Location of Facility/Program	
For the purpose(s) of _____	
This is a consent to use my own personal health information <input type="checkbox"/> Yes <input type="checkbox"/> 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 _____	
<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 Client or ADM	
<ul style="list-style-type: none"> I understand that this consent may be withdrawn or amended at any time.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 <input type="checkbox"/> is valid for 1 year <input type="checkbox"/> is valid for this request only expires on _____	
	(DD/MMM/YYYY)
Signature of Person Consenting _____	Date _____
	(DD/MMM/YYYY)

Guideline for Completing the “Consent to Use Personal Health Information Form (PHI)”

The Personal Health Information Act (PHIA) permits trustees 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 use PHI for a purpose that requires consent from the individual or a person permitted to exercise the rights of an individual.

Part 1 Consent 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 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 the trustee is requesting to use.
- Specify the purpose for which the information is to be used.
- Indicate if the consent for use is for the individual’s own PHI, if so check “yes”, if not check “no” and complete Part 3.

Part 3 Alternate Decision Maker

- 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.
 - (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 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;
 - (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 deceased, 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 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 known 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 consent is valid for one 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 client or ADM(as described in Parts 1 or 3).
- Record the date consent is obtained.
- File the completed Consent for Use PHI Form on the client’s health record.