Sunnybrook
HEALTH SCIENCES CENTRE

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION

FAX: 416-480-6123 PHONE: 416-480-4433

I Hereby Authorize: Sunnybrook Health Sciences Centre
(NAME OF PERSON/FACILITY RELEASING INFORMATION)

To Release to:
(Name and Address of Person Receiving Information - e.g. Doctor/Lawyer/ Insurance Co./Self) _____

Type of Information Required ☐ MEDICAL IMAGING (CD/FILMS) ☐ COPIES OF MEDICAL RECORDS

Will Information be Picked up In Person ☐ YES ☐ NO _____

Date(s) of Treatment: Or Medical Imaging _____

Patient's Name (PRINT): _____ (LAST NAME) _____ (FIRST NAME)

Patient's Address: _____

Patient's Date of Birth: _____ (YYYY/MM/DD) **OHIP#:** _____

Patient's EMAIL address for access to MyChart _____

Patient's Daytime Telephone Number(s): _____

Signature of Patient or Authorized Representative: _____ **Date:** _____ (YYYY/MM/DD)

Relationship to the Patient (If not the patient) _____

Signature of Witness: _____ **Date:** _____ (YYYY/MM/DD)

Print name of Witness: _____

Notes:

1. This authorization is valid for a period of ***90 days from the date of signing*** and may be rescinded or amended in writing during that period except where action has been taken based on authorization provided;
2. This authorization must contain:
   a) The *signature* of the patient (capable individual who is 14 years or older to whom the record pertains); or
   b) The *signature* of a person who is authorized by the patient to receive the information on the patient's behalf, ***accompanied by a letter consenting to this release signed by the patient***; or
   c) The signature of the patient's legal representative if the patient is deceased or has been certified mentally incompetent.
   d) The signature of the witness to the patient's or authorized representative's signature
3. This authorization shall apply only to information dated prior to date of signature;
4. If the patient does not read or understand English, the authorization form must be interpreted for the patient. The person who acts as the *interpreter must* sign the form as a *witness* to confirm that this has been done.

Faxed ***Authorization to Release Personal Health Information forms/requests for direct fulfillment to the individual to whom the information pertains are accepted,*** however two valid pieces of government issued identification, one of which must be a photo ID, will be required for identity verification before delivery of required information to the individual. Persons without a driver's license or passport may provide one valid piece of government issued identification, e.g. OHIP card.

REQUIRED FEES

Copies of Medical Records: Non-refundable search fee of $30.00 (includes first 20 pages) is required to initiate the processing of request, plus $0.25 per additional page payable upon completion of request.
Medical Imaging/CD Films: $10.00 per Medical Imaging CD is applicable

FOR OFFICE USE ONLY
HFN: _____ ID VALIDATED BY: _____