Health Records Release of Information

AUTHORIZATION FOR ACCESS OR DISCLOSURE OF PERSONAL HEALTH INFORMATION

Pursuant to Health Information Disclosure Legislation

Overview

This form is to be used to request access to your personal health information or to permit sharing your personal health information with third parties outside of TELUS Health.

Instructions - Complete the fields for each section in the attached form

Section 1 - Patient Information (the subject of the personal health information requested)

Section 2 - Release to (Requestor Contact Information) and communication preference

- If you are submitting this request as a substitute decision-maker (SDM), you must also submit one photocopy of a document that shows you are entitled to act as the substitute decision-maker for the individual identified in Section 1.

Section 3 - Describe the personal health information to be accessed or disclosed including a time frame associated with the requested record(s)

Section 4 - Authorization

- If you are a legal representative, you have confirmed the identity of your client (the subject of this request) and have provided an authorization from your client.

- As per applicable legislation, authorization must be signed by the patient or the substitute decision-maker. Requestor understands and agrees to any potential fees that accompany this request for personal health information and that response to this request will be provided within thirty (30) days, unless communicated otherwise. Authorization is valid for a 90-day period as of the date of the signature, unless specified otherwise. Authorization may be withdrawn at any time, except with respect to actions already taken before the consent was withdrawn.

Fax the completed form(s) to the appropriate contact as indicated below:

- TELUS Health MyCare: 1-604-259-3247
- TELUS Health Virtual Care: 1-855-242-1733
- Care Centres: fax as noted on clinic location website https://www.telus.com/en/health/care-centres/locations

TELUS Health

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SECTION 1: PATIENT INFORMATION

PATIENT NAME			*** DATE OF BIRTH**	DD/MM/YYYY	
	*LAST NAME	*GIVEN NAME	**HEALTH CARD NUMBER**		
MAILING ADDRESS					
	STREET NO.	STREET NAME	UNIT No.	TOWN/CITY	POSTAL CODE

SECTION 2: RELEASE TO (REQUESTOR CONTACT INFORMATION)

☐ **SELF** ☐ **CARE PROVIDER** ☐ **OTHER (PLEASE SPECIFY)**				
	ORGANIZATION	FIRST NAME	LAST NAME	TITLE
MAILING ADDRESS				
	STREET NO.	STREET NAME	UNIT NO	TOWN/CITY	POSTAL CODE
***COMMUNICATION PREFERENCE** ☐ MAIL ☐ TELEPHONE ☐ EMAIL		☐ NO ☐ YES		
	*PHONE NUMBER (DAYTIME)	* VOICEMAIL PERMISSION	EMAIL ADDRESS	

SECTION 3: PERSONAL HEALTH INFORMATION TO BE ACCESSED OR DISCLOSED

***RECORDS**	☐ FULL MEDICAL FILE ☐ MEDICAL SUMMARY OF RECENT TEST RESULTS ☐ RECORDS RELATING TO:			
***TIMEFRAME**	FROM	DD/MM/YYYY	TO	DD/MM/YYYY
***HOW DO YOU WANT TO RECEIVE THE RECORDS**	☐ PAPER ☐ PDF			
ADDITIONAL DESCRIPTION OF INFORMATION:				

SECTION 4: AUTHORIZATION

As per Health Information Disclosure legislation, authorization must be signed by the patient or the substitute decision-maker. Requestor understands and agrees to any potential fees that accompany this request for personal health information and that response to this request will be provided within thirty (30) days, unless communicated otherwise. Authorization is valid for a 90-day period as of the date of the signature, unless specified otherwise. Authorization may be withdrawn at any time, except with respect to actions already taken before the consent was withdrawn.

***PATIENT/SDM NAME (PRINT)**			**WITNESS NAME (PRINT)**		
	LAST NAME	GIVEN NAME		LAST NAME	GIVEN NAME
***SIGNATURE**		☐ Electronic	**SIGNATURE**		☐ Electronic
***DATE**	DD/MM/YYYY		**DATE**	DD/MM/YYYY	
STAFF INITIALS		☐ **FORM COMPLETED**	☐ **IDENTITY VERIFIED**	☐ **SDM DOCUMENT**	☐ **FEE SCALE PROVIDED**

Submit completed form to your provider of care

Health Records – Do Not Destroy