

Personal Health Information Access and/or Disclosure Request
Pursuant to the *Personal Health Information Protection Act, 2004 (PHIPA)*

To be completed by Patient/SDM

I, _____, authorize Runnymede Healthcare Centre to disclose the
(Print Name)
following personal health information concerning treatment from: ____/____/____ to ____/____/____
YYYY MM DD YYYY MM DD
at Runnymede Healthcare Centre:

(Description of personal health information to be disclosed)

from the records of: _____ Date of Birth: ____/____/____
(Name of Patient) YYYY MM DD

This information may be disclosed to: ☐ Myself **OR**

(Name)

(Phone Number)

(Fax Number)

(Address)

(City)

(Postal Code)

I understand that this personal health information is to be used ONLY by the recipient for the purposes of:

I hereby waive any and all claims against Runnymede Healthcare Centre in connection with the disclosure of this personal health information.

☐ Self ☐ Substitute Decision-Maker

Signature

Date

Name (print)

Relationship (if SDM*)

Address: _____ Phone No: _____
(Address) (City) (Postal Code)

*Note: (SDM) A substitute decision-maker is a person authorized under PHIPA to consent, on behalf of an individual, to disclose personal health information about the individual.

To be completed by a witness

Signature

Date

Name (print)

Relationship

Please return this form to Health Information Services



R5001000007



Health Information Services
625 Runnymede Road
Toronto, ON M6S 3A3
416-762-7316 ext. 2118
healthinfoservices@runnymedehc.ca

To be completed by receiver

Date Received

Date Returned to RHC

Received by:

Signature

Name (print)

To be completed by Health Information Services

Type of disclosure provided:

☐ Photocopies ☐ Fax/Scan ☐ View ☐ Other _____

Requester ID Verified: _____

Fee Quoted: \$ _____
Subject to current fee schedule at time of submission

Completed by:

Signature

Date

Name (print)

Title

Comments: