

Authorization for Disclosure of Clinical Record Information

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Patient Information		
		Middle Initial:
Date of birth:		
Mailing address:	Postal code:	
Medical Record Number (if available): _	Postal code: Postal code: Postal code:	
□ Pick up - Provide valid government I	D upon pick up Deliver - Address pro	ovided below unless instructed otherwise
The undersigned hereby authorizes/requi	ests the	
to provide	(Health Care Facility or H	lealth Service Provider)
to provide(Name of third party or self)	(Mailing address of	third party or self)
The reason for this request is: (you must	provide a reason if requesting the reco	rd of a deceased person)
	T	
☐ Medication reports	Treatment date(s):	
☐ Emergency records	Treatment date(s):	
☐ Hospital/inpatient records	Treatment date(s):	
☐ Clinic/outpatient records	Treatment date(s):	
☐ Laboratory reports	Treatment date(s):	
□ Pathology reports	Treatment date(s):	
☐ Radiology reports	Treatment date(s):	
☐ Other (specify):	Treatment date(s):	
☐ All records		
Patient's signature:	Witness' signature:	Date:
If the person signing is not the patient	, state the relationship and authority	to do so.
Legal Representative's signature:	Print name:	Date:
State relationship to patient:		
(please complete page 2 if requesting red		eased persons)
	(Proof of authorization to act on behalf of the patient must	•
1. This authorization may be revoked or	r amended in writing at any time prior to	the expiration date except where action
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- 1. This authorization may be revoked or amended in writing at any time prior to the expiration date except where action has been taken in reliance on the authorization.
- 2. This authorization must contain the original signature of:
 - a. Either the patient, the parent or legal guardian if the patient is under 19 years of age and unmarried*, or the legal representative if the patient is deceased or has been certified mentally incompetent, and
 - b. The witness to the patient's or legal representative's signature
- 3. Authorization must be signed within 6 months of request. Authorization is only valid for 6 months from the date the authorization was signed. Documentation must contain original signature.
- 4. Request for release of information must be dated after treatment dates.
- 5. 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. Please indicate if the interpreter is related to the patient.

*For patients between 12 and 19 years of age who wish to authorize their own release of records, please consult the Health Records Department in your community for guidance regarding the requirements of the BC Infants' Act. On completion of this form, please fax or mail it to the health records department in the facility you are requesting information from. Please look for the fax number and mailing addresses under the "locations" tab and click on " more info" for more details on the Northern Health external website.

Northern Health collects, stores and shares your personal information under the authority of the Freedom of Information and Protection of Privacy Act (British Columbia). Northern Health will take all reasonable steps to make sure your personal information is treated confidentially, stored securely and used only for the purposes of providing you with health care services and treatment. If you have any questions, please contact Northern Health's Privacy Office at 250 645-8544.





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Declaration of Status to Access Records of Incapable Minors/Adults or Deceased Persons

This is Part Two of the authorization form and *must only be filled out in full if requesting records of Incapable Minor/Adults or Deceased Persons*

- Please check the appropriate box below to indicate what authority you have to act on behalf of the patient/client.
- You must be the individual on the list and proof of the status must be provided.
- Please note if any dispute exists, or there is confusion about status, we must deny access. Applicants may appeal our decision with the Office of the Information & Privacy Commissioner.
- The form is not required if the request for records is made under Coroner's Act; the Child, Family, and Community Services Act; or other statute.

Purpose of request:		
Hierarchy of authorization:		
Complete if patient/client is currently under the age of 19 years and not capable of exercising his/her rights. Documentation should include a copy of Guardian by court order or separation agreement or, Custodial parent agreement. Note: Patient/client authorization is required if patient appears to have consented to the treatment. You must be the authorized person on the hierarchy list, in the following order stated below. Guardian by court order or separation agreement Custodian parent		
Complete according to Hierarchy if patient/client is deceased		
 □ Court appointed administrator of estate □ Committee of person (and no letters probate yet granted) □ Executor of the will (copy of the will must be provided. If will exists, it must be the person in order of the hierarchy.) □ Spouse (including common law and/or same sex spouse) □ Child of parent/client □ Brother or sister of patient/client □ Grandparent □ Other relative (birth or adopted) → Specify relationship:		
Complete according to Hierarchy if patient/client is incapable of exercising information rights		
 □ Committee of person □ Committee of estate (only when litigation guardian or committee) □ Representative with legal authority □ Spouse (including common law and/or same sex spouse) □ Child of parent/client □ Brother or sister of patient/client □ Grandparent □ Grandchild □ Other relative 		
Please note that if any dispute exists, or there is confusion about the status of the applicant, the organization must deny access to the records. Applicants may request a review of the organizations decision with the Northern Health Privacy Office (250 645-8544). Under section 52, of the Freedom of Information and Protection Act, applicants also have a right to appeal the organization's decision with the Office of the Information & Privacy Commissioner. (http://www.oipbc.org/)		
Person authorized to act in behalf of the client:		
Request received by:		
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