Interior Health

AUTHORIZATION FOR THE RELEASE OF HEALTH RECORDS

Patient Name *(last)* ______
(first) ______
DOB *(dd/mm/yyyy)* ______
PHN ______ MRN ______
Account/Visit # ______
IH USE ONLY

Please see Instructions for Submitting a Request for Access to Personal Health Records (IH form 828688) prior to completing this form. The detailed instructions provide guidance ensuring requests are completed with valid authorization and supporting documentation in order to facilitate a timely response. https://www.interiorhealth.ca/AboutUs/InformationRequests/Pages/HealthRecords.aspx

PART 1. PATIENT INFORMATION

Last Name ______ First Name ______
DOB ______ PHN ______ Email ______
Mailing Address ______
City ______ Province ______ Country ______
Postal Code ______ Phone (______) ______

Part 2. RECORDS REQUESTED

Hospital/Facility ______
Please complete and submit Request for the Release of Health Records to the appropriate site via fax or mail.

☐ Discharge Summary ☐ Physician Emergency Room Record ☐ Diagnostic Reports (Lab/Radiology)
☐ Visit Summary (income tax/insurance) ☐ Other *(specify)* ______

Date(s) of Records Requested From ______ To ______

Part 3. PERSON RECEIVING COPIES OF RECORDS

☐ Myself ***OR*** ☐ Name of person receiving the records *(Last)* ______ *(First)* ______
Name of Company or Organization *(if applicable)* ______
Mailing Address ______
City ______ Province ______ Country ______
Postal Code ______ Phone (______) ______
Records to be: ☐ Mailed ☐ Picked Up (Picture ID Required) ☐ Faxed (provide a confidential fax) ______

Part 4. PATIENT AUTHORIZATION

Patient signature required if the patient is capable of exercising their information rights, actively involved in decisions about health care and providing consent for care.

I, the patient, authorize the Hospital/Facility to release the records requested to the person named above in Part 3 "Person Receiving Copies of Records" section.

Date (dd/mm/yyyy)	Full Name	Signature

INTERNAL USE ONLY Date Received ______ ROI Log Number ______ Staff Initial ______

Permanent part of the health record

This Authorization must be signed by the patient/resident/authorized representative and must be dated within 6 months of the request being submitted. The BC Freedom of Information and Protection of Privacy Act (FIPPA) allows (30) business days to respond to all requests. Personal Information contained on this form is collected under s. 26(c) of FIPPA and will be used only for the purpose of responding to your request. If you have questions please contact the facility's Health Records Release of Information Office.

Proceed to page 2 only if you are requesting copies of records on behalf of another person

Page 2 is not required if the request for records is made under the Coroner's Act, The Child, Family and Community Services Act, or other statute.

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Part 5. AUTHORIZATION ON BEHALF OF THE PATIENT (If patient is under the age of majority and not actively involved in decisions about health care or incapable of exercising information rights.)

- Please check the appropriate part below (5a, b, or c) to indicate what authority you have to act on behalf of the patient.
- You must be the highest ranking individual shown on the list and proof of status must be provided.
- Complete all fields in part 5d, date and sign.
- Please note that if any dispute exists, or if there is confusion about status, access will be denied. Applicants may appeal with the Office of the Information & Privacy Commissioner.

Part 5a. AUTHORIZATION ON BEHALF OF A PATIENT WHO IS UNDER THE AGE OF 19 YEARS

- ☐ Parent with whom the patient primarily resides
- ☐ Parent with whom the patient does not reside but has guardianship
- ☐ Legal Guardian granted by Court Order or Separation Agreement

Part 5b. AUTHORIZATION ON BEHALF OF ADULT PATIENT

- ☐ Personal Representative (Committee of Person)
- ☐ Personal Representative (Committee of Estate)
- ☐ Litigation Guardian (see Supreme Court Civil Rules)
- ☐ Representative with legal authority (Representation Agreement)
- ☐ Spouse (including common law and/or same sex partner residing with the patient in a marriage like relationship)
- ☐ Adult Child of Patient
- ☐ Parent of Patient
- ☐ Adult Brother or Sister of Patient
- ☐ Other adult relation of Patient other than by marriage *(specify)* __________
- ☐ Other adult immediately related to Patient by marriage *(specify)* __________

Part 5c. AUTHORIZATION ON BEHALF OF A DECEASED PATIENT

Adults:

- ☐ Executor or Administrator of Estate
- ☐ Personal Representative (Committee of Person)
- ☐ Personal Representative (Committee of Estate)
- ☐ Representative with legal authority (Representation Agreement)
- ☐ Spouse (including common law and/or same sex partner residing with the patient in a marriage like relationship)
- ☐ Adult Child of Patient
- ☐ Parent of Patient
- ☐ Adult Brother or Sister of Patient
- ☐ Other adult relation of Patient other than by marriage *(specify)* __________
- ☐ Other adult immediately related to Patient by marriage *(specify)* __________

Patients under the age of 19 years:

- ☐ Executor or Administrator of Estate
- ☐ Parent with whom the patient primarily resided
- ☐ Parent with whom the patient did not reside but had guardianship (defined in the Family Law Act)
- ☐ Legal Guardian granted by Court Order or Separation Agreement

Part 5d. By signing below, I declare that I have legal authority to act on behalf of the patient and I hereby authorize the Hospital/Facility to release copies of the records requested to the person named above in Part 3 "Person Receiving Copies of Records" for the sole purpose of acting in the patient's best interest.

- ☐ I have indicated my relationship to the patient above; and
- ☐ If applicable, I have attached documentation to show my status as legal representative or guardian (e.g. copy of Will, court order, legal agreement, or other documentation).

Reason for Request __________

Date (dd/mm/yyyy)	Full Name	Signature

Permanent part of the health record