Authorization for Disclosure of Personal Health Information

CLIENT IDENTIFICATION

Name: _____ Date of Birth: _____
(Last / First / Middle) (DD/MM/YY)

Address: _____

Telephone Number: _____ MCP Number: _____

The undersigned requests ☐ access to ***or*** ☐ copies of personal health information be provided to: _____
(Person or Facility / Hospital / Clinic address & Phone Number)

Please indicate the location of records that you wish to access by ticking all that apply:

- ☐ A. M. Guy Memorial Health Centre
- ☐ Baie Verte Peninsula Health Centre
- ☐ Dr. Y.K. Jeon Kittiwake Health Centre/Bonnews Lodge
- ☐ Carmelite House
- ☐ Central Newfoundland Regional Health Centre
- ☐ Connaigre Peninsula Health Centre
- ☐ Dr. Hugh Twomey Health Centre
- ☐ Fogo Island Health Centre
- ☐ Community Health Centre (*Specify medical clinic*)_____
- ☐ Community Program Area (*Public Health/Mental Health/Community Supports/etc.*) _____
- ☐ Green Bay Health Centre
- ☐ James Paton Memorial Regional Health Centre
- ☐ Lakeside Homes
- ☐ Lewisporte Health Centre
- ☐ Notre Dame Bay Memorial Health Centre
- ☐ Valley Vista Senior Citizens Home
- ☐ Youth Treatment Centre
- ☐ Other_____

Description of information to be disclosed:

Purpose of this request: _____

_____ _____
Signature of Client / Authorized Representative Date

_____ _____
Witness Date

If the person signing is not the client, state the relationship or authority to do so: _____
(Relationship / Authority)

Please send the completed and signed form to:

Disclosure
Health Information Management & Privacy
James Paton Memorial Regional Health Centre
125 TransCanada Highway
Gander, NL A1V 1P7
Telephone: (709) 256 5520
Fax: (709) 256 2715

1. Central Health acknowledges and respects the privacy of individuals. Personal health information is disclosed in accordance with the *Personal Health Information Act, SNL2008 cP-7.01*. The information collected on this form will be used for processing your request for disclosure of personal health information.
2. The authorization must contain a valid signature of the client or representative (as defined by section 7 of the *Personal Health Information Act, SNL2008 cP-7.01*.
3. The authorization must be submitted to Central Health within 60 days of dated signature. The authorization may be revoked in writing at any time, except where disclosure has occurred based on the current signed authorization.
4. As required, copies of supporting documents may be requested to support authorized disclosure of personal health information.
5. As per policy 4-e-10 ***Fee Schedule for Disclosure of Personal Health Information***, an associated fee may apply payable prior to disclosure, except where an exemption to pre-payment applies. The current fee schedule is included on page 2 of this form.

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Revised September 2016
FRM-PHI004

Central Health

FEE SCHEDULE FOR DISCLOSURE OF PERSONAL HEALTH INFORMATION
Effective January 5, 2016

FEE SCHEDULE	
Client /Representative/Substitute Decision Maker (SDM) Request	**(CAD)**
→ Standard Fee (includes up to 10 pages)	$10.00
→ Copy fee (more than 10 pages)	$0.25 per page
→ Viewing of Health Record	No charge (1 hour)
→ Viewing of Health Record (**after 1st hour**)	$25/hr.
→ Hospital Visits (per request/per client)	$10.00
→ Time of Birth	$10.00
→ Immunization Records	No charge
→ Verification of Birth or Death	No charge
***Note: There is a $250 maximum charge to the client/representative/SDM per request**	
Workplace NL Request	
→ Standard Fee (up to 25 pages)	$25.00
→ Copy fee (more than 25 pages)	$0.25 per page
→ Additional costs for photocopying external records from outside of RHA (e.g. fetal heart monitor strips, ICU/CCU notes)	As applicable
Third-Party Request (excluding Workplace NL)	
→ Standard Fee (up to 25 pages)	$50.00
→ Copy Fee (more than 25 pages)	$0.25 per page
→ Additional Costs for photocopying outside of RHA (e.g. fetal heart monitor strips, ICU/CCU notes)	As applicable

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