Partnering for Lifelong Health

Clinton

Family Health Team

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

This form is to be used for the purpose of authorizing someone, other than you, to communicate with our staff.

(See next page for instructions)

1. Primary Patient:

Name: Last, First, MI		
Street Address		Telephone #
City	Province	Postal Code
Date of Birth mm/dd/yyyy		

2. The person listed below is authorized to access my medical information:

Name: Last, First, MI		
Street Address		Telephone #
City	Province	Postal Code
Date of Birth mm/dd/yyyy		

Relationship:

☐ Spouse/Partner ☐ Guardian ☐ Power of Attorney ☐ Other: _____
☐ Father ☐ Mother ☐ Son ☐ Daughter ☐ _____in law

3. INFORMATION TO BE RELEASED:

☐ Telephone/verbal communication (all subjects) & Document or Form Collection (*a fee may apply)

☐ Only the following subject: _____

☐ Document or Form Collection: Permission to release copies of medical documentation (*A fee may apply)

☐ All subjects except for the following: _____

4. This authorization will remain in effect until revoked by you.
If you wish to limit the duration of this authorization, please specify the end date below:
☐ End Date: _____

5. I authorize the release of my medical information in accordance with the specification listed above.
of this consent shall be kept as the original.

_____ Date: _____

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ADDITIONAL INFORMATION REGARDING DISCLOSURE OF PATIENT MEDICAL INFORMATION

Privacy regulations require your health care team not divulge any information to unauthorized persons. In today's world, it is common for a spouse or partner to arrange appointments for their family members, to check if they should come back for follow-up etc. It is permissible for a parent or legal guardian to manage these tasks for a minor. It is not permissible for a spouse to act on your behalf unless authorized. We require **written consent** to be on file.

Children that are 16 years of age or older must also grant authorization to a parent or guardian.

By default, a parent or guardian is assumed to have authorization for a minor. It becomes difficult to manage this if the surnames of any of the parents are different than the minors, resides at a different residence or there is rules regarding custody. In these cases please supply full details in writing.

Revocation. You have the right to revoke this authorization, in writing, at any time before it ends. However, your written revocation will not affect any disclosures of your medical information that have already been made, in reliance on this authorization, before the time you revoke it. In addition, if this authorization was obtained for the purpose of insurance coverage, your revocation may not be effective in certain circumstances where the insurer is contesting a claim. Your revocation must be made in writing and addressed to:

Clinton Family Health Team Box 69 105 Shipley Street Clinton ON NOM 1L0

Signatures. If you are 16 years of age or older, you are the ***only person*** who is permitted to sign a form to authorize the disclosure of your medical information. No one else can authorize disclosure of medical information for you unless they have legal rights to do so.

PLEASE DROP OFF OR MAIL THE COMPLETED FORM TO OUR OFFICE. THE SIGNED FORM WILL BE ADDED TO YOUR MEDICAL RECORDS.

Clinton Family Health Team Box 69 105 Shipley Street Clinton ON NOM 1L0