REQUEST/CONSENT FOR ACCESS/DISCLOSURE OF PERSONAL HEALTH INFORMATION

Patient Name: ______________________

Date of Birth: ______________________

MRN: ______________________

TO BE ❑ ACCESSED ❑ DISCLOSED
TO/FROM: (REQUESTERS NAME, ADDRESS AND PHONE/FAX NUMBER)

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INFORMATION	COMMENTS AND DATES
❑ Discharge Summary	______________________
❑ Operative/Pathology Reports	______________________
❑ Anaesthesia/Recovery Room	______________________
❑ Medical Imaging (X-ray, CT, MRI, Ultrasound)	______________________
❑ Laboratory Reports	______________________
❑ Consultation/Progress Notes	______________________
❑ ED Record	______________________
❑ Confirmation of Dates	______________________
❑ Summary of Chart*	______________________
❑ Complete Chart Copy	______________________
❑ Other	______________________

* Can include but not limited to discharge summary, operative and pathology reports, consultation report, medical imaging and laboratory reports

CONSENT FOR RELEASE OF PATIENT HEALTH INFORMATION
Patient consent must be obtained for disclosing personal health information to a third party (e.g. Lawyer, Insurance) or if the request is related to information from a health care organization located outside the province of Ontario.

I authorize The CHILDREN'S HOSPITAL OF EASTERN ONTARIO to access/disclose the information noted above.

______________________	______________________	______________________
Name of patient/substitute decision maker	Signature	Date

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Relationship to patient

Authorization is valid for 90 days from date of signing. Include copies of documents providing your authority as a substitute decision maker

HEALTH RECORDS USE ONLY: Completed by: ______________________ Total $: ____________ Date: ____________

Form No. 4010 Revised April 2015

STANDARD FEE SCHEDULE FOR
ACCESS/DISCLOSURE OF PERSONAL HEALTH INFORMATION

Request	Fees
Medical Professionals	NO CHARGE
Insurance Companies	$30.00 for first 1-20 pages and $0.25/page thereafter
Lawyers	$30.00 for first 1-20 pages and $0.25/page thereafter
W.S.I.B. (Ontario)	$48.15 flat rate
W.S.I.B. (other provinces)	$130.00 flat rate
Criminal Injuries Compensation	$140.00 flat rate
Confirmation of Dates of Treatment/Visit History	$10.00 flat rate
Proof of Death	$25.00 flat rate
College of Physicians & Surgeons (CPSO)	$0.25/copy
Patient/Substitute Decision Maker	$30.00 for first 1-20 pages and $0.25/page thereafter
STAT request surcharge for non-patient care related requests (within 1-5 business days) Patient/Substitute Decision Maker	$100.00 on top of the prescribed fee
STAT request surcharge for non-patient care related requests (within 1-5 business days) Lawyers/Insurance Companies/Consulting Firms	$300 on top of the prescribed fee
For supervising an individual's examination of original records	$50.00 includes up to first 60minutes and $6.75/15minutes thereafter
Off-Site Retrieval	$25.00 for non-urgent request additional surcharge
For printing a photograph from a negative or from a photograph stored in electronic form per print	$10.00 for 4" x 5"
For making and providing on an encrypted USB stick containing a copy of a record stored in electronic format	$10.00 in addition to the prescribed fee

Cheques or money order should be made payable to
Children's Hospital of Eastern Ontario and sent to the attention of
Health Records Release of Information