SickKids
Centre for Community Mental Health

Health Records department
440 Jarvis Street, Room B-06
Toronto, ON M4Y 2H4
Telephone: 416-924-1164
Fax 416-373-2003

For SickKids CCMH Staff Use	
Client #:	
Request #	
Date Received:	

Consent for the disclosure of Personal Health Information

I/we, _____, hereby authorize
(Name of client/parent/substitute decision-maker)

_____
(Person/facility from whom information is being sent)

to disclose: (check all that apply; specify further if needed)

- ☐ Assessment notes
- ☐ Closing/discharge summary
- ☐ Other _____
- ☐ Contact note dated _____
- ☐ Transfer of record

to _____
(Person/facility to whom information is to be sent – name, full address, phone number)

_____

From the record of _____ _____
(Full name of client at time of treatment) (Date of birth- dd-mmm-yyyy)

This information is to be disclosed for: (specific purpose must be stated – see instruction on reverse)

- ☐ Referral
- ☐ Personal use
- ☐ Other _____
- ☐ Treatment planning
- ☐ Medication consultation

I understand the private and confidential nature of this information and agree that it will be used only for the stated purpose(s). This authorization will be valid for 90 days of the date of signature, unless otherwise specified. I understand that I may withdraw my consent at any time by informing the centre in writing, except with respect to actions already taken before consent was withdrawn.

*NOTE: In accordance with Personal Health Information Protection Act (PHIPA) authorization must be signed by the client, and if incapable by the parent or substitute decision-maker (SDM). An SDM is a person authorized by PHIPA to consent on behalf of the individual, to disclose personal health information about the individual

_____ _____
Signature of client (**12 year and older**) Date (dd-mm-yyyy)

_____ _____
Signature of parent/substitute decision-maker Print name of parent/SDM and relationship

_____ _____
Signature of witness Print name of witness

*All requests for access to a record of personal health information must be submitted through the Health Records department. Processing time is dependent on volume of requests. SickKids CCMH has 30 days to respond to your initial request. In some circumstances we may need another 30-day extension (you will be notified if more time is required).

Instructions for completion of this form

Name of client/parent/substitute decision-maker: who is authorizing this release of personal health information?

Person/facility from whom information is being sent: who is releasing the information? Where is the information coming form?

To disclose: the nature of confidential information being disclosed must be specifically stated. Choose from the list provided, may select more than one. If what you are looking for is not listed, check other and specify the type of information you are requesting

Person/facility to whom information is to be sent: who will be receiving the requested information? Include full address and phone number

From the record of: Clients full name and date of birth. Please ensure name given is the name at the time of treatment, example, maiden name, legal name change

Information is to be disclosed for: purpose of disclosure, must be specifically stated, use other if purpose is not listed

Authorization: Must be in writing and contain the signature of the subject of the information to be released, or the legal representative or guardian of the subject, as well as the signature of a witness and date

Regarding authorization:

1. The service provider may serve as a witness

2. Authorization must be provided by a person who is mentally capable of making the decision to disclose the information.
*Consent must be signed by any patient/client 12 years of age or older.
*Consent will be accepted from a parent, guardian or substitute decision maker (SDM) if the patient/client is less than 12 years old or is deemed incapable of consenting. The SDM must be a person authorized by PHIPA to consent on behalf of the individual, to disclose PHI about the individual.

3. Authorization to release confidential information does not prevent the withholding of information that is judged likely to result in serious harm to the treatment or recovery of the client, or serious physical or emotional harm to another person. Absence of authorization does not prevent the release of information for the purpose of reporting that a child is or may be in need of protection

Renewal of consents: if consent is required beyond the maximum duration indicated, the consent must be renewed by completing a new form

Withdrawal of consent: Clients are permitted to withdraw consent at anytime by notifying the health records