



# Capital Health

Access to Personal Health Information / Legal Services

## Authorization for Release of Personal Health Information

Please drop off, fax or mail your form to: **Access to Personal Health Information**

QEII, Halifax Infirmary Site, Room 1123 - 1796 Summer Street, Halifax, NS B3H 3A7

Tel: 473-5512, Fax: 473-2091

(Please Note: Charges apply for copying records and processing requests)

Please indicate here which records you are seeking to access:

- All Capital Health Records for all facilities; **OR**
- Cobequid Community Health Centre       Dartmouth General Hospital       East Coast Forensic Hospital
- Eastern Shore Memorial Hospital       Hants Community Hospital       Musquodoboit Valley Memorial Hospital
- Nova Scotia Hospital       Public Health       Twin Oaks Memorial Hospital
- QEII Health Sciences Centre       Nova Scotia Environmental Health Centre
- Specify facility, program or service \_\_\_\_\_

**1. IDENTIFICATION INFORMATION:** Please complete this section with information relating to the person whose records are being disclosed. (Please print clearly and provide as much information as possible in this section. If the information is not complete, we may not be able to identify the person and complete your request).

Last Name	First/Given Name	Middle Initial
Previous Surname (if applicable)	Date of Birth: _____ (Year/Month/Day)	
Provincial Health Card number	Mailing Address (Street # / Unit # / Apartment #)	
Daytime Telephone number _____	Mailing Address (City, Province, Postal Code)	
	Check if person is deceased <input type="checkbox"/>	

**2. RELEASE TO:** Check each that applies

- I am requesting access to my own record      **OR**
- I am authorizing release of information to the following person(s):

Name of Person/Organization to Receive the Information requested	
Mailing Address (Street #/ Unit #/ Apartment #)	
Mailing Address (City, Province, Postal Code)	
Telephone Number (____) _____	Fax (____) _____

I authorize this release to include:

- Capital Health staff and physicians discussing verbally my personal health information.



**3. Length of Time for which Release is Valid – CHECK ONE**

I understand that unless otherwise indicated below, this Authorization will expire one (1) year after the date it was signed **OR**  
I am indicating that I want this authorization to expire as indicated below (check one):  
 Authorization expires immediately upon completion of the requested release  
 Authorization expires on (indicate specific date): \_\_\_\_\_

**4. My Authorization for Release is Limited to the following:**

Whole record \* **OR**  All records \* from the time period (year/month/day) \_\_\_\_\_ to \_\_\_\_\_  
 Visit History  
 The following specific records \_\_\_\_\_ from (year/month/day) \_\_\_\_\_ to \_\_\_\_\_  
 Cancer Centre Records  
 Diagnostic Images on CD  
 Series Visits/Outpatient Visits

\* **Does not include** financial records, Addictions and Prevention Treatment Services records (call 424-7257), but **does include** all Mental Health records if the whole record is requested.

**5. My Authorization for Release is for the following: - CHECK ONE ONLY**

View only **OR**  Photocopies (**Fees may be payable in advance**)

**6. SIGNATURES (required for all requests – please use ink)**

I give permission to Capital Health to release my personal health information as indicated in this form. This form will authorize the release of my personal health information gathered prior to the date of signature, **as well as information gathered up to one year after the date of signature unless I have otherwise indicated in Box #3.** I may withdraw my permission at any time, in writing, as long as the information has not already been released. I hereby release Capital District Health Authority and its employees and agents from any and all claims whatsoever which may arise as a result of the release of my personal health information. I agree that I am personally responsible to pay any fees associated with the release.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

**OR**

Substitute Decision Maker \*  
Signature \_\_\_\_\_ Date \_\_\_\_\_

\* Must Complete a Capital Health Declaration of Substitute Decision Maker for Release of Information Form (**CD1586MR**) – please contact APHI staff at 473-5512 if you require this form.

**FOR ACCESS TO PERSONAL HEALTH INFORMATION STAFF USE ONLY:**

Date Requested received: \_\_\_\_\_ Staff Releasing Info: \_\_\_\_\_  
Information Released and Notes: \_\_\_\_\_