**Dixie Road Medical Associates**

**AUTHORIZATION FOR DISCLOSURE**

**OF MEDICAL INFORMATION**

This form is to be used for the purpose of authorizing someone other than yourself to communicate with our staff with regard to your medical information (see reverse side for instructions).

1. **Primary Patient: COMPLETE IN FULL, 16 years of age or older**

|  |  |  |
| --- | --- | --- |
| Name-Last, First, Initial | | |
| Street Address | | Telephone # |
| City | Province | Postal Code |
| Date of Birth mm/dd/yyyy | | |

1. **The person listed below is authorized to access my medical information.**

|  |  |  |
| --- | --- | --- |
| Name-Last, First, Initial | | |
| 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

1. **INFORMATION TO BE RELEASED:**

\_\_\_\_\_ Telephone/verbal communication (all subjects)

\_\_\_\_\_ Only for following subject: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ All subjects except for following: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

A separate request (completed documentation release form) will be required for a copy of medical documentation. A copy fee may apply.

1. 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. I authorize release of my medical information in accordance with the specifications listed above. A photocopy of this consent shall be valid as the original.
2. **Signature of patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ADDITIONAL INFORMATION REGARDING DISCLOSURE**

**OF PATIENT MEDICAL INFORMATION**

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

Children who 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 from the minors’, reside at a different residence or there are 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. However, your written revocation will not affect any disclosures of your medical information that has 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 your claim. Your revocation must be made in writing and addressed to :

*Dixie Road Medical Associates, 2200 Dixie Road, Mississauga, ON L4Y 1Z4*

**Signatures.** Generally, if you are 16 years of age or older, you are the only person who is permitted to sign a form to authorize disclosure of medical information for you unless others have the right to do so.