AUTHORIZATION FOR THE RELEASE OF HEALTH RECORDS

Please fax or mail your completed request to each facility you are requesting records from.
ATTENTION: Records and Information Management

Part 1. Patient / Resident Information

LAST NAME OF PATIENT	FIRST NAME	ALSO KNOWN AS / ALIAS
MAILING ADDRESS	CITY / PROVINCE / COUNTRY	POSTAL CODE
TELEPHONE NO. (INCLUDING AREA CODE)	DATE OF BIRTH DAY | MONTH | YEAR	PERSONAL HEALTH NUMBER (CARECARD)

Part 2. Records Requested

HEALTH CENTRE/FACILITY:		
☐ VISIT SUMMARY	☐ EMERGENCY VISIT INFORMATION	☐ DIAGNOSTIC REPORTS (LAB/RADIOLOGY)
☐ PROOF OF VISIT (fees may apply)	☐ ALL or ☐ OTHER (PLEASE SPECIFY):	

DATE(S) OF RECORDS REQUESTED:______________________ TO ______________________
If you do not know exact dates please provide your best estimate

Part 3. Person Receiving Records

☐ MYSELF **OR** ☐ NAME OF PERSON RECEIVING THE RECORDS (LAST, FIRST)	NAME OF COMPANY OR ORGANIZATION (IF APPLICABLE)	
MAILING ADDRESS	CITY / PROVINCE / COUNTRY	POSTAL CODE
TELEPHONE NO. (INCLUDING AREA CODE)	RECORDS TO BE: ☐ MAILED ☐ PICKED UP (Picture ID Required)	

Part 4. Patient Authorization (12 years of age or older)

I, the patient, authorize the Health Centre(s)/Facility to release the records requested to the person named in the "Person Receiving Records" section.

SIGNATURE OF PATIENT:______________________________DATE SIGNED: ____________________

Part 5. Authorization on behalf of Patient (Please complete page 2 of form)

(If patient is under 12 years of age or unable to authorize the release of personal information.)

By signing below I confirm that I have legal authority to act on behalf of the patient and I hereby authorize the Health Centre(s)/Facility to release the records requested to the person named in the "Person Receiving Records" section.

☐ I have indicated my relationship to the patient on page 2 of this form; and
☐ If applicable, I have attached documentation to show my status as legal representative or guardian (e.g. copy of will, court order, legal agreement, or other documentation).

REASON FOR REQUEST: ____

YOUR FULL NAME: ____

YOUR SIGNATURE: DATE SIGNED:

Internal Use Only			
ID OBSERVED: ☐ DL ☐ Other: (specify) ___________	PATIENT/REP SIGNATURE (on pickup)	DATE OF RELEASE	STAFF INITIAL

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Complete this side only if Part 5 on front of form is completed

Authorization on behalf of an incapable adult

☐ **Committee** appointed by court order (where records are required to carry out committee's duties)

☐ Person acting under a **Power of Attorney** (where records are required for financial or legal matters)

☐ **Litigation Guardian** (where records are required for litigation)

☐ **Representative** under a Representation Agreement (where records are required to carry out representative's duties) If none of the above have been appointed, please explain relationship to patient:

Authorization on behalf of an incapable minor

Complete this section if patient is a minor: under 12; or under 19 and not actively involved in decisions about health care. Note: Patient authorization is required if patient is involved in decisions about care or has provided consent for care.

Guardian:

☐ by court order

☐ under a legal agreement

☐ parent who has lived with or regularly cared for child and there is no order or agreement removing my guardianship

Authorization on behalf of a deceased patient

Deceased Adult

☐ **Committee** appointed by court order

☐ If there is no Committee, **Personal Representative** (Executor or Administrator of Estate) If there is no Committee or Personal Representative:

Nearest Relative: first person referred to in the following list who is willing and able to act on behalf of deceased:

☐ Spouse

☐ Adult child

☐ Parent

☐ Adult brother or sister

☐ Other adult relation other than by marriage: ______________________

☐ An adult immediately related by marriage: ______________________

Deceased Minor (under 19)

☐ **Personal Representative** (Executor or Administrator of Estate)

☐ If there is no Personal Representative, **Guardian** (appointed by court, under an agreement, or a parent who has lived with or regularly cared for child)

If there is no Personal Representative or Guardian:

Nearest Relative: first person who is willing and able to act on behalf of deceased:

☐ Spouse

☐ Parent

☐ Adult brother or sister

☐ Other adult relation other than by marriage: ______________________

☐ An adult immediately related by marriage: ______________________

This authorization must be signed by the patient/resident/authorized representative and must be dated within 6 months of the request being submitted. The BC Personal Information Protection Act (PIPA) allows (30) business days to respond to all requests. Personal Information contained on this form is collected under s. 10(1) of PIPA and will be used only for the purpose of responding to your request. If you have questions please contact the Records and Information Management Office.