Winnipeg Regional Health Authority — Caring for Health
Office régional de la santé de Winnipeg — À l'écoute de notre santé

CancerCare Manitoba
ActionCancerManitoba

(FRANÇAIS AU VERSO)

CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION

PART 1: CONSENT FROM PATIENT/CLIENT/RESIDENT

LAST NAME ______________________ FIRST NAME ______________________

Date of Birth: D D M M M Y Y Y Y

Health Card Number: ______________________

Address: ______________________
STREET NAME AND NUMBER — CITY — PROVINCE — POSTAL CODE

Phone Numbers: Home: ( ) ________ Work: ( ) ________ Cell: ( ) ________

PART 2: DETAILS OF CONSENT

Consent to ______________________
NAME/LOCATION OF CCMB/WRHA SITE/PROGRAM

disclosing the following personal health information, specifically: ______________________

To be disclosed to: ______________________

For the purpose(s) of: ______________________

This is a consent to disclose my own information: ☐ Yes ☐ No **If NO – complete Part 3.**

PART 3: PERSON PERMITTED TO EXERCISE THE RIGHTS OF AN INDIVIDUAL

LAST NAME ______________________ FIRST NAME ______________________

Address: ______________________
STREET NAME AND NUMBER — CITY — PROVINCE — POSTAL CODE

Phone Numbers: Home: ( ) ________ Work: ( ) ________ Cell: ( ) ________

Indicate Your Authority: ______________________

PART 4: SIGN OFF

I understand that this consent may be withdrawn or amended at any time. A withdrawal does not have a retroactive effect. The third party shall not use the personal health information disclosed except for the purpose specified on this consent.

This consent: ☐ is valid for one year ☐ is valid for this request only ☐ expires on D D M M M Y Y Y Y

Signature of Person Consenting: ______________________ Date: D D M M M Y Y Y Y

DISTRIBUTION: Original to Individual's Health Record

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(ENGLISH ON REVERSE)

CONSENTEMENT À DIVULGUER DES RENSEIGNEMENTS MÉDICAUX PERSONNELS

PARTIE 1 : CONSENTEMENT DU PATIENT/CLIENT/RÉSIDENT

NOM DE FAMILLE ______________________ PRÉNOM ______________________

Date de naissance : |__|__|__|__|__|__|__|__|__| (J J M M M A A A A)

Numéro de la carte santé : |__|__|__|__|__|__|__|__|__|

Adresse : ______________________
NOM DE RUE ET NUMÉRO MUNICIPAL — VILLE — PROVINCE — CODE POSTAL

Nos de téléphone : Maison : (   ) __________ Travail : (   ) __________ Tél. Cell : (   ) __________

PARTIE 2 : DÉTAILS DU CONSENTEMENT

Consentement accordé à : ______________________
NOM/EMPLACEMENT DE L'ACTIONCANCER, DE L'ÉTABLISSEMENT OU DU PROGRAMME DE L'ORSW

pour la divulgation des renseignements médicaux personnels suivants, expressément : ______________________

____

À être divulgué à : ______________________

Dans le but de : ______________________

____

Le consentement vise la divulgation de renseignements me concernant personnellement : ☐ Oui ☐ Non **Si la réponse est NON – remplir la Partie 3.**

PARTIE 3 : PERSONNE AUTORISÉE À EXERCER LES DROITS D'UN PARTICULIER

NOM DE FAMILLE ______________________ PRÉNOM ______________________

Adresse : ______________________
NOM DE RUE ET NUMÉRO MUNICIPAL — VILLE — PROVINCE — CODE POSTAL

Nos de téléphone : Maison : (   ) __________ Travail : (   ) __________ Tél. Cell : (   ) __________

Indiquer votre autorisation : ______________________

PARTIE 4 : SIGNATURE

Je comprends que ce consentement peut être rétracté ou modifié en tout temps. La rétractation n'a pas d'effet rétroactif.
Les renseignements médicaux personnels ne peuvent pas être divulgués à d'autres fins que celles indiquées dans le présent consentement.

Le consentement : ☐ est valide pour un an ☐ n'est valide que pour la présente demande ☐ expire le |__|__|__|__|__|__|__|__|__| (J J M M M A A A A)

Signature de la personne consentante : ______________________ Date : |__|__|__|__|__|__|__|__|__| (J J M M M A A A A)

DISTRIBUTION: Original à verser dans le dossier médical

CancerCare Manitoba
ActionCancerManitoba

Guideline for Completing the "Consent to Disclose Personal Health Information (PHI) Form"

The Personal Health Information Act (PHIA) permits trustee's to use PHI without the consent of individual or a person permitted to exercise the rights of an individual, under specific circumstances. This form is to be used **only** when a trustee is required to disclose PHI for a purpose that requires consent from the individual or a person permitted to exercise the rights of an individual.

Part 1: Consent from Patient/Client/Resident

- Record the last name, first name, date of birth, health card number (the 9 digit PHIN in Manitoba or another jurisdictions health card number), address (in full) and phone numbers of the individual the information is about.

Part 2: Details of Consent

- Indicate the name of the hospital, personal care home, clinic, community health centre, and/or program such as midwifery, home care, public health, mental health etc. that is requesting to use PHI.
- Specify the PHI that is to be disclosed.
- Specify to who the PHI will be disclosed.
- Indicate if the request is for the individual's own PHI, if so check "yes", if not check "no" and complete Part 2.

Part 3: Person Permitted to Exercise the Rights of an Individual

- Record the last name, first name, complete address and phone numbers of the person permitted to exercise the rights of an individual the information is about.
- Indicate your authority to exercise the rights of the individual from the following list.

(a) any person with written authorization from the individual to act on the individual's behalf;
(b) a proxy appointed by the individual under The Health Care Directives Act;
(c) a committee appointed for the individual under The Mental Health Act if the committee has the power to make health care decisions on the individual's behalf;
(d) a substitute decision make for personal care appointed for the individual under The Vulnerable Persons Living with a mental Disability Act if the exercise of the right relates to the powers and duties of the substitute decision make;
(e) the parent or guardian of an individual who is a minor, if the minor does not have the capacity to make health care decisions;
(f) if the individual is deceased, his or her Personal Representative.

If it is reasonable to believe that no person listed in any clause above exists or is available, the adult person listed first in the following clauses who is readily available and willing to act may exercise the rights of an individual who lacks the capacity to do so:

(a) the individual's spouse, or common-law partner, with who the individual is cohabitating
(b) a son or daughter
(c) a parent, if the individual is an adult;
(d) a brother or sister;
(e) a person with whom the individual is known to have a close personal relationship;
(f) a grandparent;
(g) a grandchild;
(h) an aunt or uncle;
(i) a nephew or niece.

Ranking: The older or oldest of two or more relatives described in any clause of the above is to be preferred to another of those relatives.

Part 4: Sign Off

- Indicate if the request is valid for one year, is valid for this request only or has an expiration date by placing a check mark in the appropriate box. If the consent has an expiration date, specify the date.
- Signature of the patient/client/resident or person permitted to exercise the rights of the individual (as described in Parts 1 or 3)
- Record the date consent is obtained.