Sinai Health

Consent for Disclosure of Personal Health Information

Clearly Imprint Patient Identification

☐ **Mount Sinai Hospital**
600 University Avenue, Room 182
Toronto, ON, Canada M5G 1X5 **T:** (416) 586-4800, Ext. 2651 **F:** (416) 586-3181
Email: Release.ofInformationMSH@sinaihealth.ca

☐ **Bridgepoint Active Health Care**
1 Bridgepoint Drive, Room A3.C85-1
Toronto, ON M4M 2B5 **T:** (416) 461-8251, Ext. 2040 or 2299 **F:** (416) 470-6739
Email: HealthRecords@sinaihealthsystem.ca

Delivery

Please select the preferred delivery format of the record (see delivery conditions and fees on the back of this form):

☐ Paper Copy ☐ USB Key ☐ Email ☐ Mail ☐ Pick-up
☐ CD ☐ Fax ☐ In person review (a copy is not provided)

Reason

Please select the reason for the request (see documentation requirements on the back of this form):

☐ Personal (patient/SDM) ☐ Medical (health care provider) ☐ Legal ☐ Insurance ☐ Estate Settlement
☐ Other (provide additional details) _____

Patient Information

Patient Name: _____ Date of Birth: _____ Health Card #: _____
LAST NAME FIRST NAME (YYYY MM DD)

Address: _____

City: _____ Province: _____ Country: _____ Postal Code: _____

Telephone #: _____ Email Address: _____

Fax #: _____

Requested Information

Please provide any relevant details that may assist in identifying the location of the record (e.g. name of health care provider(s) or clinic(s), type of service, date ranges, etc.): _____

_____

_____

Treatment or Admission Dates:

1. Date of Visit: _____ (YYYY MM DD) Date of Discharge: _____ (YYYY MM DD)
2. Date of Visit: _____ (YYYY MM DD) Date of Discharge: _____ (YYYY MM DD)

Recipient Information

Complete this section only if the request involves sending the record to an individual other than the above listed patient.
I authorize Sinai Health System to disclose personal health information to:

Recipient Name: _____ Name of Organization: _____
LAST NAME FIRST NAME

Address: _____

City: _____ Province: _____ Country: _____ Postal Code: _____

Telephone #: _____ Email Address: _____

Fax #: _____

MS704

Consent

This form must be signed by the patient or the Substitute Decision Maker (SDM) in order to process the request for records. I have read and agree to the conditions outlined on the back of this form.

Print name of Patient: _____

Print name of Substitute Decision Maker (if applicable): _____

Signature of Patient: _____

Signature of Substitute Decision Maker (if applicable): _____

Date of Signature: _____ (YYYY MM DD)

Substitute Decision Maker Contact information (if different than patient):

_____
Address and /or Telephone Number

INSTRUCTIONS

1. **Where to Submit Request:** Please submit the completed form in person or by email, fax or postal mail to the appropriate department as outlined below:
    a. **Mount Sinai Health Record Services** is able to provide copies of records for Mount Sinai inpatient, emergency department and day surgery visits only.
    b. Mount Sinai Outpatient Clinics (e.g. Family Health Team, Prenatal Clinic, Fracture Clinic) are each able to provide copies of records for their individual clinic.
    Visit the Mount Sinai website (http://www.mountsinai.on.ca/patients) or call the main hospital phone line (416-586-4800) to obtain the appropriate clinic contact information. It is recommended that you contact the clinic directly for further information before submitting this form. Please note that it may be necessary to reach out to multiple clinics depending on where care was received.
    c. **Mount Sinai Medical Imaging** is able to provide copies of images and reports for Mount Sinai medical imaging visits.
    For further information about requesting records, please contact (416) 586-4800 Ext. 4425.
    d. **Bridgepoint Health Record Services** is able to provide copies of records for all Bridgepoint inpatient and outpatient visits.
2. **Documentation Requirements:**
    a. A copy of the patient's government issued identification must be submitted with this form (i.e. driver's licence or health card).
    b. If the recipient listed on this form is not the patient, a copy of the recipient's government issued identification must also be submitted with this form.
    c. Estate settlement requests require a copy of the first and last page of the will or the certification of appointment.
    d. Legal and Insurance requests require a formal letter of request and copy of patient consent.
3. **Fees:** There are set fees related to requests for patient records, which are estimated after receiving all required documentation. Please contact Health Records if you require more information about the fees.
4. **Delivery Conditions:**
    a. Records provided on paper, USB or CD are sent by regular postal mail.
        i. If you wish to pick up the records in person, please specify this on the form.
        ii. Mount Sinai records can be made available on CD, USB or Email if the visit occurred after January 1, 2014.
        iii. Only paper copies of records (no CD, USB or Email) are available from Bridgepoint.
    b. Regardless of the delivery method, the recipient is responsible for protecting records from unauthorized use or disclosure.
5. **Timeline for Response:** Please allow 30 days for your request to be processed. If additional time is required, you will be notified.
6. **Expiry:** This form is valid for three (3) months after the date of signature unless otherwise specified. The request may be withdrawn in writing at any time. Records that are provided in electronic format are not encrypted.