# AUTHORIZATION FOR THE RELEASE OF HEALTH RECORDS

**Please fax or mail your completed request to each hospital/facility you are requesting records from.**
**ATTENTION: Health Information Management, Release of Information Office**

## 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

HOSPITAL(S)/FACILITY:

| ☐ VISIT SUMMARY | ☐ EMERGENCY VISIT INFORMATION | ☐ DIAGNOSTIC REPORTS (LAB/RADIOLOGY) |
|---|---|---|
| ☐ PROOF OF VISIT (fees may apply) | ☐ OUTPATIENT ☐ 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 Hospital(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 Hospital(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 |

*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 Freedom of Information and Protection of Privacy Act (FIPPA) allows (30) business days to respond to all requests.*

*Personal Information contained on this form is collected under s. 26(c) of FIPPA and will be used only for the purpose of responding to your request. If you have questions please contact the Health Information Management Release of Information Office.*

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

### Authorization on behalf of an incapable adult

Any of the following, acting within their duties or powers, may provide authorization on behalf of an adult:

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

☐ **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 and intended use of records:

### 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**

☐ **Executor or Administrator of Estate**

☐ If there is no **Executor or Administrator of Estate, Committee of Person,** appointed by court order

If there is no Executor, Administrator of Estate or Committee:

**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)**

☐ **Executor or Administrator of Estate**

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

If there is no Executor, Administrator of Estate 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: _____