ABBOTSFORD REGIONAL HOSPITAL & CANCER CENTRE
32900 Marshall Road
Abbotsford, BC V2S 0C2

Abbotsford Hospital: Phone: 604-851-4700 (local 646790)
Fax: 604-851-4902
Cancer Centre: Phone: 604-851-4710 (local 645176)
Fax: 604-851-4738

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

PATIENT IDENTIFICATION

_____
Patient Name (Last Name, First Name)

_____
Also Known As / Alias

DD MM YYYY _____
Date of Birth Chart Number

_____
Personal Health Number (PHN)

REQUEST FOR INFORMATION

This information is to be released to:

_____
☐ Myself **OR** ☐ Name of Person/Organization

_____
Address

_____
City Province Postal Code

( ) _____
Telephone

INFORMATION TO BE RELEASED

Please indicate what specific information or reports are required:_____

_____

_____

Dates of Service to be Released: From:_____ To:_____

PATIENT AUTHORIZATION

I,_____, hereby authorize
(Print Name of Patient or Authorized Representative)

☐ Abbotsford Regional Hospital
☐ BC Cancer Agency
☐ Other: _____

to release the above specified information to me or to the person/organization stated above.

I consent to the use of this information only for the purpose of: (optional)_____

_____ _____
SIGNATURE of Patient/Resident/Client/Authorized Representative DATE (DD/MM/YYYY)

_____

If **NOT** signed by patient, state **RELATIONSHIP** to patient and **COMPLETE BACK OF FORM**

Internal Use Only

Identification Presented:_____ ID Viewed by:_____
Date Copies Released: _____ # of Pages:_____
Information: ☐ Mailed Out ☐ Picked-Up ☐ Other_____

This authorization is valid for six (6) months from the signature date.
If signed by patient's authorized representative, proof of authority to act on the patient's behalf must be attached.
Allow up to thirty (30) business days to process request.

DECLARATION OF STATUS TO ACCESS RECORDS OF INCAPABLE MINORS/ADULTS OR DECEASED PERSONS

- Please check the appropriate box below to indicate what authority you have to act on behalf of the patient/client.
- You must be the highest ranking individual shown on the list and **proof of status must be provided.**
- Please note that if any dispute exists, or there is confusion about status, we must deny access. Applicants may appeal our decision with the Office of the Information & Privacy Commissioner.

HIERARCHY OF AUTHORIZATION

Complete if patient/client is currently under the age of 19 years and not capable of exercising his/her rights.
Note: Patient/client authorization is required if patient appears to have consented to the treatment.

- ☐ Guardian by Court Order or Separation Agreement
- ☐ Custodial Parent

Complete if patient/client is deceased.

- ☐ Court Appointed Administrator of Estate
- ☐ Committee of Person (and no Letters Probate yet granted)
- ☐ Executor of the Will
- ☐ Spouse (including common law and/or same sex spouse)
- ☐ Child of Patient/Client
- ☐ Parent of Patient/Client
- ☐ Brother or Sister of Patient/Client
- ☐ Other Relative (Birth or Adopted).
  Specify relationship:_____

In the space provided below, please describe why you are requesting the records. You must provide enough information so that the organization can determine if you are acting on behalf of the deceased:

_____

_____

_____

_____

Complete if patient/client is incapable of exercising information rights.

- ☐ Committee of Person
- ☐ Committee of Estate (only when Litigation Guardian or Committee)
- ☐ Representative with legal authority
  If none exists, nearest relative*
- ☐ Spouse
- ☐ Child of Patient/Client
- ☐ Parent of Patient/Client
- ☐ Brother or Sister of Patient/Client

*Temporary Substitute Decision Maker if appointed.