West Carleton

Family Health Team

Form: C1

AUTHORIZATION TO COMMUNICATE MEDICAL INFORMATION VERBALLY

This form is to be used for the purpose of authorizing someone other than yourself, to communicate with our staff, with regard to your medical information. ***(See reverse side for instructions.)***

1. Primary Patient, ***COMPLETE IN FULL 16 years of age and older.***

Name - Last, First, MI		
Street Address		**Telephone # (xxx) xxx-xxxx**
City	**Province**	**Postal Code**
Date of Birth mm/dd/yyyy		

2. The person listed below is authorized to access my medical information.

Name - Last, First, MI		
Street Address		**Telephone # (xxx) xxx-xxxx**
City	**Province**	**Postal Code**
Date of Birth mm/dd/yyyy		

Relationship: ☐ Spouse/Partner ☐ Guardian ☐ Power of Attorney ☐ Other ________________________________
☐ Father ☐ Mother ☐ Son ☐ Daughter ☐ ______________ in law

3. INFORMATION TO BE RELEASED:

☐ Telephone/verbal communication (all subjects)

☐ Only for the following subject: ____

☐ All subjects except for the following: ____

A separate request (completed documentation release form) will be required for a copy of medical documentation. A copy fee may apply.

4. This authorization will remain in effect until revoked by you. See items 7/8 below.
If you wish to limit the duration of this authorization, please specify the end date below:

☐ End Date: _____________________________

5. I authorize release of my medical information in accordance with the specification listed above.
A photocopy of this consent shall be valid as the original.

6. Signature of patient ____ **Date** ___________________________

7. I wish to revoke all/any authorizations previously submitted. A photocopy of this form shall be valid as the original.

8. Signature of patient ____ **Date** ___________________________

ADDITIONAL INFORMATION REGARDING DISCLOSURE OF PATIENT MEDICAL INFORMATION

Privacy regulations require your health care team not divulge any information to unauthorized persons. In today's world, it is common for a spouse or partner to arrange appointments for their family members, to check if they should come back for a follow-up, etc. It is permissible for a parent or legal guardian to manage these tasks for a minor. But not permissible for a spouse to act on your behalf unless authorized. We required **written consent** to be on file.

Children that are 16 years of age or older must also grant authorization to a parent or guardian.

By default, a parent or guardian is assumed to have authorization for a minor. It becomes difficult to manage this if the surnames of any of the parents are different than the minors, reside at a different residence or there is rules regarding custody. In these cases please supply full details in writing.

Revocation. You have the right to revoke this authorization, in writing, at any time before it ends. However, your written revocation will not affect any disclosures of your medical information that have already been made, in reliance on this authorization, before the time you revoke it. In addition, if this authorization was obtained for the purpose of insurance coverage, your revocation may not be effective in certain circumstances where the insurer is contesting a claim. Your revocation must be made in writing and addressed to:

West Carleton Family Health Team, 119 Langstaff Dr., Carp, ON, K0A 1L0

Signatures. Generally, if you are 16 years of age or older, you are the only person who is permitted to sign a form to authorize the disclosure of your medical information. A spouse can not authorize disclosure of medical information for you unless they have legal rights to do so.

PLEASE DROP OFF, FAX , SCAN AND EMAIL, OR MAIL VIA CANADA POST THE COMPLETED FORM TO OUR OFFICE. THE SIGNED FORM WILL BE ADDED TO YOUR MEDICAL RECORDS.

Mail to: West Carleton Family Health Team, Box 218, 119 Langstaff Dr. Carp, ON, K0A 1L0

Fax: 613-839-3273 Email: reception@wcfht.ca