Nova Scotia
Health Authority

REQUEST AND AUTHORIZATION TO RELEASE INFORMATION

*Identify facility/hospital or program:*________________________________

1. PATIENT IDENTIFICATION INFORMATION: (please print)

Last Name: ______________________ First Name: ______________________ Middle Initial: _____

Previous Surname: ______________________ Date of Birth: ______________________

Health Card Number: ______________________ Daytime Telephone Number: ______________________

Unit number: ______________________

2. I REQUEST:

- ☐ To view the original record
- ☐ A copy of my visit history.
- ☐ A copy of the original record or specific documents set out in section 4.

3. AUTHORIZE THE RELEASE OF INFORMATION TO THE FOLLOWING PERSON(S):

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4. MY AUTHORIZATION FOR RELEASE IS LIMITED TO THE FOLLOWING RECORDS:

- ☐ Emergency Visits Date:______________________
- ☐ Day Surgery Visit Date:______________________
- ☐ Ambulatory Care Visit Date:______________________
- ☐ Other (specify): ______________________________________
- ☐ Inpatient Visit Date:______________________

I require the following records from my inpatient visit:

- ☐ Discharge Summary
- ☐ Consultant Report(s)
- ☐ Operative Report(s)
- ☐ Laboratory Reports
- ☐ History & Physical
- ☐ Tissue Reports
- ☐ Diagnostic Reports (eg x-ray) Specify: ______________________________________
- ☐ All Records(Inpatient & Ambulatory Care)
- ☐ Progress Notes

PROGRAMS: Addiction Services/ Public Health

Specify Information Requested: ______________________________________

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5. PERMISSION FOR HEALTH CARE PROVIDER(S) TO :

☐ Give verbal communication to the parties set out in section 3 above, up to and including six months from the date hereof.

6. THE HEALTH INFORMATION IS BEING REQUESTED FOR:

☐ Second opinion
☐ Referral
☐ Insurance company
☐ Residence relocation
☐ Community Services
☐ Personal knowledge
☐ Legal purposes
☐ Law Enforcement Investigation
☐ Other

7. SIGNATURE: (Required for all requests)

I give permission to the Cape Breton District Health Authority (insert site or hospital) ____________________ to release copies of my health care record or health information to the person or organization named in Section 3. The District, its employees and attending physician(s) are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein. This authorization shall remain valid until ____________________ . If no date is indicated this form is valid for 6 (six) months past the date signed.

In the event I request the information be transmitted, I release the Cape Breton District Health Authority from any liability which may arise as a result of the fax transmission not being properly carried out or being recovered by a third party unauthorized to receive the information.

I may withdraw my permission at any time, in writing, as long as the information has not already been released. If the patientis unable to sign, the substitute decision maker may sign on his/her behalf. Proof of authority for individuals other than the legal next of kin to sign on the patient's behalf must accompany this form. This includes but is not limited to copies of Guardianship Orders and/or Enduring Power of Attorney.

I understand that although the Hospitals Act Section 71 allows release of health information at the request of the patient, Section 71(3) allows the hospital or physician to refuse to make available copies of health information if there are reasonable grounds to refuse. This refusal must be in writing.

Patient Signature: ______________________ Date: ______________
DD / MM / YYYY

Substitute Decision maker: ______________________ Date: ______________
DD / MM / YYYY

Relationship to the Patient: ______________________

Witness Signature: ______________________ Date: ______________
DD / MM / YYYY

For information on the fee for processing and copying charges call appropriate facility.

MR4652R (04/2004)

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