



REQUEST TO RELEASE PERSONAL HEALTH INFORMATION

I hereby consent and direct CancerCare Manitoba to provide personal health information regarding:

_____ **Date of Birth:** _____

of _____
(Address)

PHIN: _____ **MHSC:** _____ **Home #:** _____ **Work #:** _____

concerning the following specific information: _____

Date(s) and service(s) provided: _____

(Facility/Department/Program/Clinic/Service)

to: **Name:** _____ **Phone #:** _____

Address: _____

(Facility/Department/Program/Clinic/Service)

Client Signature: _____ **Date:** _____

I authorize _____ to view and/or receive copies of the above-noted personal health information in my place.

Consent on Behalf of Client

I _____ am exercising the rights for the client in accordance of

(Print Name)

The Personal Health Information Act, Section 60

- A by any person with written authorization from the individual to act on the individual's behalf;
- B by a proxy appointed by the individual under *The Health Care Directives Act*;
- C by a committee appointed for the individual under *The Mental Health Act* if the committee has the power to make health care decisions on the individual's behalf;
- D by a substitute decision maker for personal care appointed for the individual under *The Vulnerable Persons Living with a Mental Disability Act* if the exercise of the right relates to the power and duties of the substitute decision maker;
- E by the parent or guardian of an individual who is a minor, if the minor does not have the capacity of make health care decisions; or
- F if the individual is deceased, by his or her personal representative.

If representing an agency, state name of agency: _____

Signature: _____ **Telephone:** _____ **Date:** _____

You will be contacted within 30 days of the receipt of your request. At that time, the availability of the information will either be confirmed to you or you will be informed that your request cannot be granted. If the information is available you will be charged a processing fee of \$25.00 to access the information. If you are requesting a copy, the cost will be \$0.50 per page for photocopies and \$8.00 for retrieval from off site storage.

To be filled out by Privacy Officer (or designate):

Signature: _____ Date: _____