CancerCare Manitoba
ActionCancerManitoba

GOVERNING DOCUMENTS

Policy and Procedure

Title:	**Consent To Use Or Disclose Personal Health Information**
Policy Number:	06.029 *(formerly 02.012)*
Effective Date:	February 10, 2012
Revised Date:	March 11, 2019
Approving Body:	President and CEO
Authority:	CancerCare Manitoba Act
Responsible Officer:	President and CEO
Delegate:	Director, Cancer Clinical Information Management
Contact:	Cancer Clinical Information Management and CCMB Privacy Officer
Applicable to:	CCMB Staff and Physicians

1.0 **BACKGROUND:**
Not Applicable

2.0 **PURPOSE:**

2.1 To detail the conditions and restrictions on the Trustee to obtain Express or Implied Consent.

2.2 To ensure consent is obtained in accordance with *The Personal Health Information Act* ("PHIA").

3.0 **DEFINITIONS:**

3.1 **Access:** The right of an Individual, or a Person Permitted to Exercise the Rights of an Individual, to examine (view) and receive a copy of the Individual's Personal Health Information Maintained by the Trustee in accordance with the Trustee's established policies and procedures.

3.2 **Demographic Information:** An Individual's name, address, telephone number, and email address.

3.3 **Disclosure of Personal Health Information:** Revealing the Personal Health Information outside the Trustee, i.e. to other Trustees, to family and friends of the Individual, or to other persons legally entitled to have Personal Health Information released to them. As an employee or agent of a Trustee when authorized to disclose, you are only permitted to disclose the minimal amount of information required as authorized by the Act.

3.4 **Express Consent:** Consent given directly by an Individual in oral, written or electronic form. For example, completion of a consent form by an Individual that authorizes the Disclosure of the Individual's own Personal Health Information is a form of Express Consent.

3.5 **Health Care:** Any care, service or procedure provided to diagnose, treat or maintain an Individual's health; provided to prevent disease or injury or promote Health Care; or that affects the structure or a function of the body and includes the sale or dispensing of a drug, device, equipment or other item pursuant to a

prescription.

3.6 **Health Care Facility:** A hospital, personal care home, Psychiatric Facility, medical clinic, laboratory, CancerCare Manitoba and community health centre or other facility in which Health Care is provided and that is designated in the PHIA regulations.

3.7 **Health Professional:** A person who is licensed or registered to provide health care under an Act of the Legislature or who is a member of a class of persons designated as health professionals in the PHIA regulations.

3.8 **Implied Consent:** In all circumstances, the purpose of the Use or disclosure would become reasonably obvious to the Individual the information is about (or another Person Permitted to Exercise the Right of an Individual), it is reasonable to expect that they would consent and the information is used or disclosed only for the purpose it was collected.

3.9 **Individual:** A patient or client receiving Health Care services within a CCMB Health Care Facility. For the purpose of Access, correction, Use and Disclosure of Personal Health Information includes Persons Permitted to Exercise the Rights of an Individual.

3.10 **Knowledgeable Consent:** Consent is knowledgeable if the Individual who gives it has been provided with the information that a reasonable person in the same circumstances would need in order to make a decision about the Use or Disclosure of the information.

3.11 **Maintain:** In relation to personal health information, to have custody or control of the information.

3.12 **Personal Health Information:** Recorded information about an identifiable Individual that relates to:

- the Individual's health, or Health Care history, including genetic information about the Individual;
- the provision of Health Care to the Individual; or
- payment for Health Care provided to the Individual;

and includes:

- the PHIN (personal health identification number) and any other identification number, symbol or particular assigned to an Individual; and
- any identifying information about the Individual that is collected in the course of, and is incidental to, the provision of Health Care or payment for Health Care;

and for further clarity includes:

- personal information such as financial position, home conditions, domestic difficulties or any other private matters relating to the Individual which have

been disclosed to the Trustee; and
- any Personal Health Information exchanged verbally about the Individual.

3.13 **Personal Representative:**

- an Executor/Executrix or joint Executor/Executrix named in a deceased Individual's will; or
- a court appointed Administrator or joint Administrator of a person's estate.

3.14 **Persons Permitted to Exercise the Rights of an Individual:**

3.14.1
a) Any person with written authorization from the Individual to act on the Individual's behalf;
b) A proxy appointed by the Individual under *The Health Care Directives Act*;
c) 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) 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 powers and duties of the substitute decision maker;
e) The parent or guardian of an Individual who is a minor, if the minor does not have the capacity to make Health Care decisions;
f) If the Individual is deceased, his or her Personal Representative.

3.14.2 If it is reasonable to believe that no person listed in any clause of 2.14.1 exists or is available, the adult person listed first in the following who is readily available and willing to act may exercise the rights of an Individual who lacks the capacity to do so:

a) The Individual's spouse, or common-law partner, with whom the Individual is cohabiting;
b) A son or daughter;
c) A parent, if the Individual is an adult;
d) A brother or sister;
e) A person with whom the Individual is known to have a close personal relationship;
f) A grandparent;
g) A grandchild;
h) An aunt or uncle;
i) A nephew or niece

Ranking: The older or oldest of two or more relatives described in any clause of 2.14.2 is to be preferred to another of those relatives.

3.15 **Privacy Officer:** An employee designated by CancerCare Manitoba or the Health Care Facility whose responsibilities include dealing with requests from Individuals who wish to examine and copy or to correct Personal Health Information collected and Maintained by the Trustee and facilitating the Trustee's compliance with PHIA. The definition is intended to mean the Privacy Officer and/or their delegate. At

CancerCare Manitoba, the Medico-Legal Correspondent assists in this designate capacity.

3.16 **Psychiatric Facility:** A place designated in the regulations of *The Mental Health Act* as a facility for the observation, assessment, diagnosis and treatment of persons who suffer from mental disorders.

3.17 **Trustee:** A Health Professional, Health Care Facility, public body, or health services agency that collects or maintains Personal Health Information.

3.18 **Use:** Any activity involving personal health information within the Trustee. Use includes accessing, looking at and sharing the information collected by the Trustee for the purpose of providing health care. Use also includes, but is not limited to processing, reproduction, transmission and transportation of Personal Health Information. As an employee or agent of a Trustee, you should only be using the minimal amount of information required to do your job.

4.0 **POLICY:**

4.1 A Trustee shall obtain an Individual's consent, for the Use or Disclosure of Personal Health Information including Demographic Information, when required under *The Personal Health Information Act.*

4.2 When PHIA requires an Individual's consent to Use or Disclose Personal Health Information, the consent must:

- relate to the purpose for which the information is used or disclosed;
- be knowledgeable and understood by the Individual;
- be voluntary; and
- not be obtained through misrepresentation.

4.3 Consent may be expressed or implied and need not be in writing.

4.4 Consent must be express, and not implied, if the Trustee:

- makes a Disclosure to a person who is not a Trustee; or
- makes a Disclosure to another Trustee, but the Disclosure is not for the purpose of providing Health Care or assisting in providing Health Care.

4.5 The Trustee may act in accordance with an Express written consent or a record of an Express Consent having been given and obtained by another Trustee, without verifying that the consent meets the requirements stated in section 3.2, unless the Trustee has reason to believe that the requirements have not been met.

4.6 An Individual may give consent subject to conditions as long as the conditions do not restrict or prohibit the Trustee from recording Personal Health Information that is required by law, or by established standards, or by professional or institutional practice.

4.7 An Individual who has given consent, whether Express or Implied, to the Use or Disclosure of Personal Health Information may withdraw it by notifying the Trustee. A withdrawal does not have a retroactive effect.

5.0 **PROCEDURE:**

5.1 Where consent is necessary to Use or Disclose Personal Health Information, the Trustee shall determine whether consent will be Implied or Express and if Express, consent will be sought from the Individual.

5.2 When a Trustee determines that the Personal Health Information can be Used or Disclosed in accordance with the Implied Consent model, the Personal Health Information Used or Disclosed and the reason for Use or Disclosure shall be documented in the Individual's health record.

5.3 When a Trustee determines that Express Consent is required for Use or Disclosure of the Personal Health Information, the Trustee must obtain consent from the Individual the information is about by:

- completing the Consent to Use or Disclose Personal Health Information Form; or
- document in the Individual's health record that verbal consent was obtained and the reason for the Use or Disclosure.

5.4 The Site Privacy Officer (or designate) may be consulted to determine whether Implied or Express Consent should be obtained, on a case-by-case basis. At CancerCare Manitoba, the Medico-Legal Correspondent assists in this designate capacity.

6.0 **REFERENCES:**

6.1 *WRHA -Consent to Use or Disclose Personal Health Information - Policy # 10.40.105*
6.2 *The Personal Health Information Act* (Manitoba)
6.3 *The Personal Health Information Act Regulations*
6.4 *Consent to Use Personal Health Information (Appendix A)*
6.5 *Consent to Disclose Personal Health Information (Appendix B)*

Policy Contact: All enquiries relating to this policy should be directed to:	
Name:	
Title/Position:	Director, Cancer Clinical Information Management and Privacy Officer
Phone:	204-792-2535
E-mail:	
Address: (if required):	

DOCUMENTATION	
Policy Location: This policy is located (hard and e-copy formats):	
1.	The original signed and approved policy is on file in the Executive Office, CCMB
2.	The e-copy is on file in the CCMB Governing Documents Library, SharePoint
3.	

Revision History:

Date	Version	Status	Author	Summary of Changes
dd/mm/yyyy	#	Initial, Draft Final Minor/Major revision		
10/02/2012	1	Initial		
30/10/2015	2	Minor revision	L Costa Policy Team	Minor revisions only.
28/03/2018	2	Minor revision	S.Friedenberger	Reformatted to new template
11/03/2019	3	Minor revision	CCIM Manager	Changes to Privacy Manager and Department Director

Approvals Record:
This Policy requires approval by:

Approval		
Date	**Name / Title**	**Signature**
	Not required.	

FINAL APPROVAL:

Date	**Name / Title**	**Signature**
11/03/2019	Dr. S. Navaratnam President and CEO, CCMB	*Original signed by* *Dr. S. Navaratnam*

APPENDIX A

Winnipeg Regional Health Authority / Office régional de la santé de Winnipeg — Caring for Health / À l'écoute de notre santé

CancerCare Manitoba / ActionCancerManitoba

(FRANÇAIS AU VERSO)

CONSENT TO USE PERSONAL HEALTH INFORMATION

PART 1: CONSENT FROM PATIENT/CLIENT/RESIDENT

LAST NAME _____ FIRST NAME _____

Date of Birth: _____ (D D M M M Y Y Y Y) Health Card Number: _____

Address: _____ (STREET NAME AND NUMBER) (CITY) (PROVINCE) (POSTAL CODE)

Phone Numbers: Home: ( ) _____ Work: ( ) _____ Cell: ( ) _____

PART 2: DETAILS OF CONSENT

Consent to _____ (NAME/LOCATION OF WRHA SITE/PROGRAM)

using the following personal health information, specifically: _____

_____

For the purpose(s) of: _____

_____

This is a consent to use my own information: ☐ Yes ☐ No **If NO – complete Part 3.**

PART 3: PERSON PERMITTED TO EXERCISE THE RIGHTS OF AN INDIVIDUAL

LAST NAME _____ FIRST NAME _____

Address: _____ (STREET NAME AND NUMBER) (CITY) (PROVINCE) (POSTAL CODE)

Phone Numbers: Home: ( ) _____ Work: ( ) _____ Cell: ( ) _____

Indicate Your Authority: _____

PART 4: SIGN OFF

I understand that this consent may be withdrawn or amended at any time. A withdrawal does not have a retroactive effect. The personal health information shall not be used except for the purpose specified on this consent.

This consent: ☐ is valid for one year ☐ is valid for this request only ☐ expires on _____ (D D M M M Y Y Y Y)

Signature of Person Consenting: _____ Date: _____ (D D M M M Y Y Y Y)

04/10 *DISTRIBUTION: Original to Individual's Health Record*

Winnipeg Regional Health Authority / Office régional de la santé de Winnipeg — Caring for Health / À l'écoute de notre santé

CancerCare Manitoba / ActionCancerManitoba

(ENGLISH ON REVERSE)

CONSENTEMENT À DIVULGUER DES RENSEIGNEMENTS MÉDICAUX PERSONNELS

PARTIE 1 : CONSENTEMENT DU PATIENT/CLIENT/RÉSIDENT

_____ _____
NOM DE FAMILLE PRÉNOM

Date de naissance : _____ (J J M M M A A A A) Numéro de la carte santé : _____

Adresse : _____
NOM DE RUE ET NUMÉRO MUNICIPAL VILLE PROVINCE CODE POSTAL

Nos de téléphone : Maison : (____) _____ Travail : (____) _____ Tél. Cell : (____) _____

PARTIE 2 : DÉTAILS DU CONSENTEMENT

Consentement accordé à : _____
NOM/EMPLACEMENT DE L'ÉTABLISSEMENT OU DU PROGRAMME DE L'ORSW

pour la divulgation des renseignements médicaux personnels suivants, expressément : _____

_____

À être divulgué à : _____

Dans le but de : _____

_____

Le consentement vise la divulgation de renseignements me concernant personnellement : ☐ Oui ☐ Non **Si la réponse est NON – remplir la Partie 3.**

PARTIE 3 : PERSONNE AUTORISÉE À EXERCER LES DROITS D'UN PARTICULIER

_____ _____
NOM DE FAMILLE PRÉNOM

Adresse : _____
NOM DE RUE ET NUMÉRO MUNICIPAL VILLE PROVINCE CODE POSTAL

Nos de téléphone : Maison : (____) _____ Travail : (____) _____ Tél. Cell : (____) _____

Indiquer votre autorisation : _____

PARTIE 4 : SIGNATURE

Je comprends que ce consentement peut être rétracté ou modifié en tout temps. La rétractation n'a pas d'effet rétroactif.
Les renseignements médicaux personnels ne peuvent pas être divulgués à d'autres fins que celles indiquées dans le présent consentement.

Le consentement : ☐ est valide pour un an ☐ n'est valide que pour la présente demande ☐ expire le _____ (J J M M M A A A A)

Signature de la personne consentante : _____ Date : _____ (J J M M M A A A A)

DISTRIBUTION: Original à verser dans le dossier médical

APPENDIX B

Winnipeg Regional Health Authority / Office régional de la santé de Winnipeg — Caring for Health / À l'écoute de notre santé

CancerCare Manitoba / ActionCancerManitoba

(FRANÇAIS AU VERSO)

CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION

PART 1: CONSENT FROM PATIENT/CLIENT/RESIDENT

LAST NAME _____ FIRST NAME _____

Date of Birth: D D M M M Y Y Y Y Health Card Number: _____

Address: _____ STREET NAME AND NUMBER CITY PROVINCE POSTAL CODE

Phone Numbers: Home: ( ) _____ Work: ( ) _____ Cell: ( ) _____

PART 2: DETAILS OF CONSENT

Consent to _____ NAME/LOCATION OF WRHA SITE/PROGRAM

disclosing the following personal health information, specifically: _____

To be disclosed to: _____

For the purpose(s) of: _____

This is a consent to disclose my own information: ☐ Yes ☐ No **If NO – complete Part 3.**

PART 3: PERSON PERMITTED TO EXERCISE THE RIGHTS OF AN INDIVIDUAL

LAST NAME _____ FIRST NAME _____

Address: _____ STREET NAME AND NUMBER CITY PROVINCE POSTAL CODE

Phone Numbers: Home: ( ) _____ Work: ( ) _____ Cell: ( ) _____

Indicate Your Authority: _____

PART 4: SIGN OFF

I understand that this consent may be withdrawn or amended at any time. A withdrawal does not have a retroactive effect. The third party shall not use the personal health information disclosed except for the purpose specified on this consent.

This consent: ☐ is valid for one year ☐ is valid for this request only ☐ expires on D D M M M Y Y Y Y

Signature of Person Consenting: _____ Date: D D M M M Y Y Y Y

04/10 *DISTRIBUTION: Original to Individual's Health Record*

Winnipeg Regional Health Authority / Office régional de la santé de Winnipeg — Caring for Health / À l'écoute de notre santé

CancerCare Manitoba / ActionCancer Manitoba

(ENGLISH ON REVERSE)

CONSENTEMENT À DIVULGUER DES RENSEIGNEMENTS MÉDICAUX PERSONNELS

PARTIE 1 : CONSENTEMENT DU PATIENT/CLIENT/RÉSIDENT

NOM DE FAMILLE _____ PRÉNOM _____

Date de naissance : J J M M M A A A A Numéro de la carte santé : _____

Adresse : _____
NOM DE RUE ET NUMÉRO MUNICIPAL VILLE PROVINCE CODE POSTAL

Nos de téléphone : Maison : ( ) _____ Travail : ( ) _____ Tél. Cell : ( ) _____

PARTIE 2 : DÉTAILS DU CONSENTEMENT

Consentement accordé à : _____
NOM/EMPLACEMENT DE L'ÉTABLISSEMENT OU DU PROGRAMME DE L'ORSW

pour la divulgation des renseignements médicaux personnels suivants, expressément : _____

_____

À être divulgué à : _____

Dans le but de : _____

_____

Le consentement vise la divulgation de renseignements me concernant personnellement : ☐ Oui ☐ Non **Si la réponse est NON – remplir la Partie 3.**

PARTIE 3 : PERSONNE AUTORISÉE À EXERCER LES DROITS D'UN PARTICULIER

NOM DE FAMILLE _____ PRÉNOM _____

Adresse : _____
NOM DE RUE ET NUMÉRO MUNICIPAL VILLE PROVINCE CODE POSTAL

Nos de téléphone : Maison : ( ) _____ Travail : ( ) _____ Tél. Cell : ( ) _____

Indiquer votre autorisation : _____

PARTIE 4 : SIGNATURE

Je comprends que ce consentement peut être rétracté ou modifié en tout temps. La rétractation n'a pas d'effet rétroactif.
Les renseignements médicaux personnels ne peuvent pas être divulgués à d'autres fins que celles indiquées dans le présent consentement.

Le consentement : ☐ est valide pour un an ☐ n'est valide que pour la présente demande ☐ expire le J J M M M A A A A

Signature de la personne consentante : _____ Date : J J M M M A A A A

DISTRIBUTION: Original à verser dans le dossier médical