Bruyère

PATIENT ACCESS TO THEIR HEALTH RECORD

- ☐ **Élisabeth Bruyère Hospital** - 43 Bruyère St., Ottawa ON K1N 5C8 - Tel.: 613-562-6005
- ☐ **Saint-Vincent Hospital** - 60 Cambridge St. N., Ottawa ON K1R 7A5 - Tel.: 613-562-6005
- ☐ **Greystone Village Retirement** - 225 Scholastic Dr, Ottawa, ON K1S 5W2 - Tel.: 613-562-6005
- ☐ **Saint-Louis Residence** - 879 Hiawatha Park Rd., Orléans ON K1C 2Z6 - Tel.: 613-562-6005
- ☐ **Élisabeth Bruyère Residence** - 75 Bruyère St., Ottawa ON K1N 5C8 - Tel.: 613-562-6005
- ☐ **Bruyère Family Medicine Centre** - 75 Bruyère St., Ottawa ON K1N 5C8 - Tel.: 613-241-3344
- ☐ **Primrose Family Medicine Centre** - 35 Primrose Ave, Ottawa ON K1R 0A1 - Tel.: 613-230-7788

SECTION A – Patient Information

Patient Name*: _____ (Last Name) _____ (First Name) Date of Birth*: _____ (DD/MM/YYYY)

Address*: _____

Health Card#: _____ Tel*.: _____ E-mail Address: _____

*mandatory information

SECTION B – Details of Request

☐ Request in person access to view my health record ☐ Request a copy of my health record

Please select the reason for the request (see documentation requirements <u>on page 2</u> of this form):

☐ Patient ☐ Health Care Provider ☐ Legal ☐ Insurance ☐ Estate Settlement ☐ SDM / POA (Only if patient is incapable)

Other (provide additional details): _____

Please select the preferred delivery format of the record (see delivery conditions and fees <u>on page 2</u> of this form):

☐ Paper Copy ☐ USB Key ☐ Secure File Sharing ☐ Mail ☐ Fax ☐ Pick-Up

SECTION C – Requested Information

Please provide any relevant details that may assist in identifying the location of the record (e.g. name of health care provider(s) or clinic(s), type of service, etc.): _____

_____

Please specify your date range: _____

Please select the type of clinical information you are seeking access to:

☐ Physician Discharge Summary ☐ Clinical History and Physical Assessment ☐ Consultations

☐ Reports from Allied Health Professionals (Psychology, Physiotherapy, Occupational Therapy, Social Work, etc.)

☐ Lab Test Results ☐ Diagnostic Imaging Results ☐ Other: _____

SECTION D – Recipient Information

This section is to be completed ONLY if the request involves sending the record to an individual other than the above listed patient. I authorize Bruyère to disclose personal health information to:

Recipient Name: _____ (Last Name) _____ (First Name) Name of Organization: _____

Address: _____

Tel.: _____ Fax#: _____ E-mail Address: _____

SECTION E – Consent

This form must be signed by the patient or the Substitute Decision Maker (SDM), Power of Attorney (POA), or Executor (if applicable) in order to process the request for records. I have read and agree to the conditions outlined <u>on page 2</u> of this form.

Print name of Patient: _____

Signature of Patient: _____

Print name of POA, SDM, or Executor (if applicable): _____

Signature of POA, SDM, or Executor (if applicable): _____

Date of Signature: _____ (DD/MM/YYYY)

Please print and sign the form manually

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INSTRUCTIONS

1. **Where to Submit Request:** Please submit the completed form in person or by email, fax or postal mail to the appropriate department as outlined below:
   a. **Bruyère Health Records Department** is able to provide copies of records for Bruyère inpatient, Greystone inpatient, Saint-Louis Residence, Élisabeth Bruyère Residence, Outpatient Ambulatory Stroke, and Physical Medicine and Rehabilitation visits only. For further information, please contact 613-562-6005.
   b. **Bruyère Outpatient Clinics** (e.g. Geriatric Day Hospital, Bruyère Memory Program, Photoderm & Dermatology) are each able to provide copies of records for their individual clinic. *Visit the Bruyère website (www.bruyere.org/en/services) to obtain the appropriate clinic contact information. It is recommended that you contact the clinic directly for further information before submitting this form. Please note that it may be necessary to reach out to multiple clinics depending on where care was received.*
   c. **Bruyère and Primrose Family Medicine Clinics.** For patients of the Bruyère Academic Family Health Team, please contact the clinic where you are a patient to obtain information on how you can submit the request form. *For Bruyère FMC, call 613-241-3344 and for Primrose FMC, call 613-230-7788*.
   d. **Bruyère Diagnostic Imaging** is able to provide copies of images and reports for Bruyère diagnostic imaging visits. *For further information about requesting records, please contact 613-562-6262 ext. 6316*

2. **Documentation Requirements:**
   a. A copy of the patient/POA/SDM/Executor of Estate's government issued identification must be submitted with this form (i.e. driver's licence).
   b. If the recipient is not the patient, a copy of the requestor's government issued photo identification must also be submitted with this form (excluding Legal and Insurance requests)
   c. Legal and Insurance requests require a formal letter of request and a copy of patient consent.
   d. Power of Attorney requests require a copy of the Power of Attorney documentation.
   e. Estate settlement requests require a copy of the first and last page of the will or the certification of appointment.

3. **Fees:** There are set fees related to requests for patient records, which vary based upon the method of delivery. Please contact Health Records if you require more information about the fees. (Note: For requests pertaining to Bruyère and Primrose Family Medicine Clinics, please contact the individual clinic for information about fees)
   - Photocopy *($30 administrative fee + $0.25 per copy after 20 pages + tax)*.
   - Digital version of health record on USB Key *($30 administrative fee + cost of USB Key + tax)*.
   - Digital version of health record available for download via secure file sharing *($30 administrative fee +tax)*.

4. **Consent:**
   a. Either express written consent or implied consent is necessary for the collection, use and disclosure of personal health information. Although implied consent is generally sufficient when providing health care, there are situations where express consent must be obtained.
   b. Express written consent must contain the original signature of the patient, the power of attorney, the substitute decision maker or the estate trustee.
   c. The consent must be specific (relate to specific information to be disclosed), must be signed and dated within 60 days of the request, and follow, and not precede, the date that the personal health information was documented.
   d. If the requester represents an organization such as a law firm or insurance company the request must include a separate cover letter on official letterhead giving the name and address of the person requesting the information, which reports are being requested, and the reason for the request.
   e. Implied consent may be assumed for disclosure to a health information custodian within the circle of care, outside Bruyère Continuing Care. Written consent of the patient or substitute decision maker is not required unless we were explicitly instructed not to make the disclosure. Request must be received on official letterhead or on the organization's request for personal health information form.
   f. The personal health information contained on this form is collected pursuant to the *Personal Health Information Protection Act, 2004* ("the Act") and will be used for the purpose of responding to your request for access pursuant to section 54 of the Act
   g. Consult the Bruyère Continuing Care Privacy and Access to Information Officer if you have any questions at 613-562-6262, ext. 1687, or privacy@bruyere.org.

5. **Delivery Conditions:** Records provided on paper or USB are sent by regular postal mail. If you wish to pick up the records in person, please specify this on the form. Regardless of the delivery method, the recipient is responsible for protecting records from unauthorized use or disclosure.

6. **Timeline for Response:** Please allow 30 days for your request to be processed. If additional time is required, you will be notified.

7. **Expiry:** This authorization is valid for a period of 60 days following the date this document was signed. The request may be withdrawn in writing at any time. Records that are provided in electronic format are not encrypted.