New Vision
Family Health Team

Consent for Disclosure of Medical Information

There may be circumstances when as a patient you prefer or require a designated relative or friend of your choosing to receive your medical information. These reasons may include:

- Language or communication barriers
- Difficulty understanding medical information
- Difficulty with recording details or appointment information due to disability or other impairments

Examples of the types of medical information that may be relayed to your designated relative or friend include:

- Medical history
- Test results
- Diagnosis
- Treatment plan
- Medications
- Appointment information
- Appointment reminders

By filling out this following form, you as the patient give New Vision Family Health Team permission to disclose all or select aspects of your medical information to your designated relative or friend. **Social work consult notes are not included in this consent and will not be disclosed.**

Be aware there are inherent risks with disclosing your medical information to your designated person. Appropriate or inappropriate dissemination of your medical information by your designated person may have foreseen or unforeseen negative consequences, personal or financial.

Please note: If you already have *power of attorney* papers pertaining to personal care, you still need to fill out this form as power of attorney does not take effect until you are incapable of making decisions. A copy of your power of attorney should still be brought into our office so we can take a copy for your chart.

Patient Information

Family Physician Name: _____

First Name:_____Last Name: _____

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

Address:_____

City:_____Province:_____Postal Code: _____

Designated Person Information

First Name:_____Last Name: _____

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

Address:_____

City:_____Province:_____Postal Code: _____

Primary Phone Number:_____Ok to leave messages? ☐ Yes ☐ No

Relationship of designated person to patient? _____
Note: designated person must be age 18+

Medical information to be disclosed:

o Any medical information (including history, test results, diagnosis, treatment plan, medications, appointment information and reminders). **Social work consult notes are not included in this consent and will not be disclosed.**

OR

o Only appointment information (including reminders)

Reason for needing your medical information to be disclosed to designated person:

o Language or communication barrier
o My designated person has more medical knowledge than me
o Convenience
o Other: _____

Is New Vision Family Health Team allowed to disclose your medical information to your designated person via paper copies (i.e. hard copies)? ☐ Yes ☐ No

Patient Declaration

This authorization is valid until:

o I notify New Vision Family Health Team ***OR*** ☐ This date: _____

Please note: You can revoke this authorization at any time in writing. For immediate revocation, please call our office at 519-578-3510.

Through signing this form, I hereby authorize New Vision Family Health Team to communicate and disclose my medical information as outlined above to my designated person(s) as named above. I also acknowledge that I have read and understand this consent form and agree to all the terms as described above.

Patient Signature:_____Date: _____

In-office Use:

Witness Name:_____Date: _____

Signature: _____