IWK Health
Release of Information
5850/5980 University Ave.
PO Box 9700
Halifax, NS B3K 6R8 Canada
Tel: 902.470.7540 ext. 3
www.iwk.nshealth.ca

Authorization for Release of Health Information

Please complete form and fax to (902) 470–8851 or mail to Release of Information Office

or email to: releaseofinformation@iwk.nshealth.ca

❑ **Processing may take up to 30 days**

1. Patient identification information: *(please print)*

Last Name: _____ Given Name(s): _____

Previous Surname: _____ Date of Birth (yyyy/MON/dd): _____

Address: _____

_____ Phone Number: _____

A minor with capacity to consent must sign this form (as per PHIA www.novascotia.ca/DHW/PHIA)

2. I request: *(please check one)*

❑ Email of record _____

❑ Paper copy (under 50 pages) ❑ CD of record ❑ To view the original record

3. Release records to: *(please check one)*

❑ **I am requesting access to the record OR**

❑ **I authorize the release of information to the following person(s):** *(Name of person/organization to Receive the information):* _____

Address: _____

Email address: _____

Telephone Number: _____ *Fax Number:* _____

***** Please Note: This person will be asked to show photo ID if picking up records in person **.***

4. My authorization for release is limited to the following records: *(please check only those that apply)*
Processing may take up to 30 days.

❑ Specific records: List specific records requested and relevant dates, or date range
(e.g. Emergency records from xx date, or physiotherapy records from xx to xx date)

_____

_____

_____

❑ Visit History – Fee = $11.50 tax included

❑ Verification of Birth, include mother's full name, date of birth, child's full name and date of birth

❑ Time of Birth, include mother's full name, date of birth, child's full name and date of birth

❑ All Records (inpatient and outpatient care)

❑ Mammogram images – contact DI @ 470–6331 (complete this form)

❑ Breast Density Assessment – email to NSBSP–Booking–Office@iwk.nshealth.ca or fax to 902–473–3959

5. Fee Schedule: *(set out in Regulations to the Personal Health Information Act for reasons other than ongoing healthcare.)*

- There is a $30.00 (plus HST) **non–refundable** fee to request records payable **before requests will be processed.** Additional fees may apply (depending on size of request, format of request, etc.) Invoice will be forwarded. Payment due prior to release.
- View fee schedule at www.iwk.nshealth.ca

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6. Relationship to the patient: *(please check one)*

❑ *Self* ❑ *Substitute Decision Maker* ❑ *Other*_____

A minor with capacity to consent must sign this form (as per PHIA www.novascotia.ca/DHW/PHIA)

IWK must check ID to verify an individual's authority to access information, before releasing health records. If you are mailing/faxing this form, please enclose a clear photocopy of one piece of government issued personal identification (ensure photocopy shows your photograph *and* your signature). Please be ready to show government issued photo identification to IWK staff if you are coming in person.

Print Full Name _____

Signature *(required for all requests)* _____ ***Date*** *(yyyy/MON/dd)* _____

❑ Copy of photo government issued ID included Verified by IWK Staff _____

***** Consent expires 90 days after date of signature. You may withdraw your consent at any time in writing **.***

7. TO BE COMPLETED ONLY WHEN APPLICANT CANNOT PROVIDE PROOF OF IDENTITY

I _____ *(print FULL name)* certify that the applicant _____ *(print FULL name)* has been known to me personally as a _____ *(insert in what capacity, e.g. employee, client, patient, etc.)* for _____ years, and that I witnessed him/her complete and sign the attached Authorization for Release of Health Information form.

Print Name_____

Signature _____ Date (yyyy/MON/dd):_____

Occupation: _____ Address: _____

8. For Release of Information OFFICE Use Only: