AUTHORIZATION FOR THE RELEASE OF HEALTH RECORDS

Please fax or mail your completed request to each hospital/facility you are requesting records from.
ATTENTION: Health Information Management, Release of Information Office

Part 1. Patient / Resident Information

LAST NAME OF PATIENT	FIRST NAME	ALSO KNOWN AS / ALIAS
MAILING ADDRESS	CITY / PROVINCE / COUNTRY	POSTAL CODE
TELEPHONE NO. (INCLUDING AREA CODE)	DATE OF BIRTH DAY | MONTH | YEAR	PERSONAL HEALTH NUMBER (CARECARD)

Part 2. Records Requested

HOSPITAL(S)/FACILITY:

☐ VISIT SUMMARY	☐ EMERGENCY VISIT INFORMATION	☐ DIAGNOSTIC REPORTS (LAB/RADIOLOGY)
☐ PROOF OF VISIT (fees may apply)	☐ ALL or ☐ OTHER (PLEASE SPECIFY):	

DATE(S) OF RECORDS REQUESTED: _____ TO _____
If you do not know exact dates please provide your best estimate

Part 3. Person Receiving Records

☐ MYSELF **OR** ☐ NAME OF PERSON RECEIVING THE RECORDS (LAST, FIRST)	NAME OF COMPANY OR ORGANIZATION (IF APPLICABLE)	
MAILING ADDRESS	CITY / PROVINCE / COUNTRY	POSTAL CODE
TELEPHONE NO. (INCLUDING AREA CODE)	RECORDS TO BE: ☐ MAILED ☐ PICKED UP (Picture ID Required)	

Part 4. Patient Authorization (12 years of age or older)

I, the patient, authorize the Hospital(s)/Facility to release the records requested to the person named in the "Person Receiving Records" section.
SIGNATURE OF PATIENT: _____ DATE SIGNED: _____

Part 5. Authorization on behalf of Patient (Please complete page 2 of form)

(If patient is under 12 years of age or unable to authorize the release of personal information.)

By signing below I confirm that I have legal authority to act on behalf of the patient and I hereby authorize the Hospital(s)/Facility to release the records requested to the person named in the "Person Receiving Records" section.

☐ I have indicated my relationship to the patient on page 2 of this form; and
☐ If applicable, I have attached documentation to show my status as legal representative or guardian (e.g. copy of will, court order, legal agreement, or other documentation).

REASON FOR REQUEST: _____

YOUR FULL NAME: _____

YOUR SIGNATURE: _____ DATE SIGNED: _____

Internal Use Only			
ID OBSERVED: ☐ DL ☐ Other: (specify) _____	PATIENT/REP SIGNATURE (on pickup)	DATE OF RELEASE	STAFF INITIAL

This authorization must be signed by the patient/resident/authorized representative and must be dated within 6 months of the request being submitted. The BC Freedom of Information and Protection of Privacy Act (FIPPA) allows (30) business days to respond to all requests.

Personal Information contained on this form is collected under s. 26(c) of FIPPA and will be used only for the purpose of responding to your request. If you have questions please contact the Health Information Management Release of Information Office.

STOP Complete this side only if Part 5 on front of form is completed

Authorization on behalf of an incapable adult

Any of the following, acting within their duties or powers, may provide authorization on behalf of an adult:

☐ **Committee** appointed by court order (where records are required to carry out committee's duties)

☐ Person acting under a **Power of Attorney** (where records are required for financial or legal matters)

☐ **Litigation Guardian** (where records are required for litigation)

☐ **Representative** under a Representation Agreement (where records are required to carry out representative's duties)

If none of the above have been appointed, please explain relationship to patient:

Authorization on behalf of an incapable minor

Complete this section if patient is a minor:

- under 12; or
- under 19 and not actively involved in decisions about health care.

Note: Patient authorization is required if patient is involved in decisions about care or has provided consent for care.

Guardian:

☐ by court order

☐ under a legal agreement

☐ parent who has lived with or regularly cared for child and there is no order or agreement removing my guardianship

Authorization on behalf of a deceased patient

Deceased Adult

☐ **Committee** appointed by court order

☐ If there is no Committee, **Personal Representative** (Executor or Administrator of Estate)

If there is no Committee or Personal Representative:

Nearest Relative: first person referred to in the following list who is willing and able to act on behalf of deceased:

- ☐ Spouse
- ☐ Adult child
- ☐ Parent
- ☐ Adult brother or sister
- ☐ Other adult relation other than by marriage: _____
- ☐ An adult immediately related by marriage: _____

Deceased Minor (under 19)

☐ **Personal Representative** (Executor or Administrator of Estate)

☐ If there is no Personal Representative, **Guardian** (appointed by court, under an agreement, or a parent who has lived with or regularly cared for child)

If there is no Personal Representative or Guardian:

Nearest Relative: first person who is willing and able to act on behalf of deceased:

- ☐ Spouse
- ☐ Parent
- ☐ Adult brother or sister
- ☐ Other adult relation other than by marriage: _____
- ☐ An adult immediately related by marriage: _____

Authorization Instructions: Release of Health Records

Please note: We will return your authorization form to you if you have not completed all required parts.

Step 1: Complete the Following Parts on the Authorization Form

Part 1: Fill out this part completely.

Part 2: Check all the boxes corresponding to the records you would like. If you do not know the exact date(s) of the records you are requesting, provide your best estimate.

Part 3: Fill out this part completely. Please include a daytime telephone number and a return address at which you can be reached, as we may need to contact you to properly process your authorization form.

Part 4: If you are the patient requesting your own records and are 12 years of age or older, you must sign and date this part.

Please Note: Parents/guardians, if your child is over 12 years of age, your child MUST sign the authorization form to obtain their records.

Part 5: If the patient is a child under 12 years of age or otherwise unable to consent (e.g., mentally incompetent, deceased), you must complete this section in full, including the reason for your request. If you require more space, please attach an additional sheet of paper to your authorization form. Please include any documentation supporting your request.

1. If your child is under the age of 12 years, you may be asked to provide supporting documentation proving you are a guardian. Acceptable supporting documentation would include, but is not limited to, a letter from a lawyer, school teacher, or a doctor stating that they have knowledge that you are a guardian.

   Please note that Section 40 of the Family Law Act states that a child's guardian may exercise all guardian responsibilities as long as they do so in consultation with the child's other guardian(s), unless consultation would be unreasonable or inappropriate in the circumstances.

Please Note: If you are requesting the records of a deceased patient, you MUST ensure that your authorization form also includes the following:

2. A copy of the deceased patient's will, letters probate, or letters of administration naming you (or the requestor) as the deceased patient's representative.

3. If no personal representative is named, you may act on the deceased's behalf if you are the nearest relative of the deceased patient. Those who may act for the deceased patient have priority in the following order: spouse, child of mature age (12 years of age or older), parent, sibling, and lastly, any other next of kin who have reached the age of majority.

4. Health care records are an individual's personal records, and considered private. Upon death, a person does not lose their legal right to privacy. We are required by law to obtain a comprehensive explanation for the reason you are seeking the deceased patient's records, including an explanation of how you are acting in the deceased patient's best interests.

5. If you are the personal representative or nearest relative of the deceased patient you must print your full name, sign and date this part.

Step 2: Mail or fax your completed authorization form to each hospital/facility you are requesting your records from. Refer to the Contact Information document for addresses and fax numbers.

(Important Note: Please do not send duplicate requests, as this will only delay your authorization.)

Have questions or need help? Call the Release of Information Office at the hospital/facility you are requesting records from. Refer to the Contact Information document for phone numbers.

PLEASE FAX OR MAIL YOUR REQUEST TO EACH HOSPITAL/FACILITY YOU ARE REQUESTING RECORDS FROM
ATTENTION: HEALTH INFORMATION MANAGEMENT, RELEASE OF INFORMATION OFFICE

Abbotsford Regional Hospital
32900 Marshall Rd, Abbotsford, BC V2S 0C2
Fax: (604) 851-4902 Tel: (604) 851-4700, Ext 646790

BC Children's Hospital and BC Women's Hospital
4500 Oak St, Vancouver, BC V6H 3V5
Fax: (604) 875-2292 Tel: (604) 875-3450

BC Women's Health Centre
F2-4500 Oak St, Vancouver, BC V6H 3N1
Fax: (604) 875-3136 Tel: (604) 875-3669/3670

BCCA – Abbotsford
32900 Marshall Rd, Abbotsford, BC V2S 0C2
Fax: (604) 851-4738 Tel: (604) 851-4710, Ext 645176

BCCA – Fraser Valley
13750 96 Ave, Surrey, BC V3V 1Z2
Fax: (604) 930-4096 Tel: (604) 930-4073

BCCA – Kelowna
399 Royal Ave, Kelowna, BC V1Y 5L3
Fax: (250) 712-3977 Tel: (250) 712-3900
If your last name starts with A-L, Ext 686822
If your last name starts with M-Z, Ext 686814

BCCA – Prince George
1215 Lethbridge St, Prince George, BC V2M 7E9
Fax: (250) 645-7366 Tel: (250) 645-7316

BCCA – Vancouver
600 W. 10th Ave, Vancouver, BC V5Z 4E6
Fax: (604) 877-0702 Tel: (604) 877-6000, Ext 672334

BCCA – Victoria
2410 Lee Ave, Victoria, BC V8R 6V5
Fax: (250) 519-2033 Tel: (250) 519-5589

Burnaby Hospital
3935 Kincaid St, Burnaby, BC V5G 2X6
Fax: (604) 412-6177 Tel: (604) 412-6219

Chilliwack General Hospital
45600 Menholm Rd, Chilliwack, BC V2P 1P7
Fax: (604) 795-4136 Tel: (604) 702-4753, ext 614753

Delta Hospital
5800 Mountain View Blvd, Delta, BC V4K 3V6
Fax: (604) 946-8642 Tel: (604) 946-1121, ext 783525

Eagle Ridge Hospital
475 Guildford Way, Port Moody, BC V3H 3W9
Fax: (604) 469-3205 Tel: (604) 469-3239

Forensic Psychiatric Hospital
70 Colony Farm Rd, Coquitlam, BC V3C 5X9
Fax: (604) 523-7897 Tel: (604) 524-7732

Fraser Canyon Hospital
1275 7 Ave, Hope, BC V0X 1L4
Fax: (604) 860-7716 Tel: (604) 860-7728

GF Strong Rehab Centre
4255 Laurel St, Vancouver, BC V5Z 2G9
Fax: (604) 731-5091 Tel: (604) 714-4158

Holy Family Hospital (c/o St. Paul's Hospital)
1081 Burrard St, Vancouver, BC V6Z 1Y6
Fax: (604) 806-9015 Tel: (604) 806-8099

Langley Memorial Hospital
22051 Fraser Hwy, Langley, BC V3A 4H4
Fax: (604) 533-6458 Tel: (604) 534-4121, Ext 745272

Lion's Gate Hospital
231 E. 15th St, North Vancouver, BC V7L 2L7
Fax: (604)984-5718 Tel: (604) 984-5719

Mission Memorial Hospital
7324 Hurd St, Mission, BC V2V 3H5
Fax: (604) 826-4043 Tel: (604) 814-5166

Mt. St. Joseph's Hospital (c/o St. Paul's Hospital)
1081 Burrard St, Vancouver, BC V6Z 1Y6
Fax: (604) 806-9015 Tel: (604) 806-8099

Peace Arch Hospital
15521 Russell Ave, White Rock, BC V4B 2R4
Fax: (604) 535-4535 Tel: (604) 535-4506, Ext 757547

Pemberton Health Centre
1403 Portage Rd, Pemberton, BC V0N 2L0
Fax: (604) 894-9618 Tel: (604) 894-6939

Powell River General Hospital
5000 Joyce Ave, Powell River, BC V8A 5R3
Fax: (604) 485-3252 Tel: (604) 485-3211, Ext 4312

Richmond Hospital
7000 Westminster Hwy, Richmond, BC V6X 1A2
Fax: (604) 244-5196 Tel: (604) 244-5108

Ridge Meadows Hospital
11666 Laity St, Maple Ridge, BC V2X 5A3
Fax: (604) 463-1830 Tel: (604) 466-7902

Riverview Hospital (c/o Forensic Psychiatric Hospital)
70 Colony Farm Rd, Coquitlam, BC V3C 5X9
Fax: (604) 523-7897 Tel: (604) 524-7732

Royal Columbian Hospital
330 E. Columbia St, New Westminster, BC V3L 3W7
Fax: (604) 520-4724 Tel: (604) 520-4431, Ext 525886

R.W. Large Memorial Hospital
88 Waglisla St, Bella Bella, BC V0T 1Z0
Fax: (250) 957-2612 Tel: (250) 957-2314

St. Paul's Hospital
1081 Burrard St, Vancouver, BC V6Z 1Y6
Fax: (604) 806-9015 Tel: (604) 806-8099

Sechelt Hospital
5544 Sunshine Coast Hwy, Sechelt, BC V0N 3A0
Fax: (604) 885-8601 Tel: (604) 885-2224, Ext 4254

Squamish General Hospital
38140 Behrner Dr, Squamish, BC V8B 0C8
Fax: (604) 892-6072 Tel: (604) 892-6018

Sunny Hill Health Centre
3644 Slocan St, Vancouver, BC V5M 3E8
Fax: (604) 453-8305 Tel: (604) 453-8350

Surrey Memorial Hospital, Jim Pattison Outpatient Care and Surgery Centre
13750 96 Ave, Surrey, BC V3V 1Z2
Fax: (604) 588-3387 Tel: (604) 585-5666, Ext 772474

UBC Hospital
2211 Wesbrook Mall, Vancouver, BC V6T 2B5
Fax: (604) 822-7284 Tel: (604) 822-7248

Vancouver General Hospital
855 W. 12th Ave, Vancouver, BC V5Z 1M9
Fax: (604) 875-5635 Tel: (604) 875-4070

Vancouver Community and Mental Health Records
200-520 W. 6th Ave, Vancouver, BC V5Z 4H5
Fax: (604) 874-7622 Tel: (604) 708-5264

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