WINDSOR
Family | Health | Team

Personal Health Information Directive

Use this form to let us know about collecting, using and disclosing the patient's personal health information

Patient Name: _____ **Patient D/O/B:** _____
(print name of patient) (YYYY/MM/DD)

Full Consent	I consent to the collection, use and disclosure of personal health information but only as is necessary to fulfill Windsor Family Health Team's lawful purposes. Please refer to Windsor Family Health Team's Privacy Statement for a listing of lawful purposes.	**Please check:** ☐

OR

Consent Directive	I consent to the collection, use and disclosure of personal health information as is necessary for all of Windsor Family Health Team's lawful purposes, except as follows: _____ _____	**Please check:** ☐

AND/OR

Consent Directive Family/ Caregiver	I consent to the collection, use and disclosure of the Patient's personal health information to: _____ (print name of person to whom you are assigning consent) For any or all of the following purposes (check any that apply) ☐ Book and/ or cancel my office appointments ☐ Receive reminders or notice of my appointments ☐ Pick up my medical records/ documents as my designate with official I.D. ☐ Discussing health concerns/ diagnoses/ medications	**Please check:** ☐

OR

Consent Withdrawal	I withdraw all previous consent given for the collection, use and disclosure of personal health . I understand that this withdrawal: • may have implications to the Patient which have been explained to me. • does not have retroactive effect; and • does not affect the collection, use and disclosure of personal health information by Windsor Family Health Team where the collection, use and disclosure is permitted or required by law without consent. I understand that consent can be reinstated at any time.	**Please check:** ☐

Authority	
Please Check as Applicable	**Required Proof**
☐ I am the patient.	○ Government photo ID
If individual consenting is not the patient and the patient is capable – one of the two must apply.	
☐ The patient is at least 16 and has given me written authorization to act for him/her.	○ Government photo ID ○ Written authorization within 6 months
☐ The patient is less than 16 and I am a custodial parent or I represent a children's aid society and the information does not relate to treatment in connection with which the subject individual has made her or his own decision in accordance with the *Health Care Consent Act*, 1996 or counselling in which the subject individual has participated on his or her own under the *Family Services Act*.	○ Government photo ID ○ Proof of status
If the patient is <u>not</u> capable – all must apply.	
☐ I am at least 16 or the parent of the patient. ☐ I am not prohibited by court order or separation agreement from having access to the patient or from giving or refusing consent on the patient's behalf. ☐ I am one of the following vis a vis the patient (please check as applicable): ☐ There is nobody on the above list that ranks higher than me who it would be possible to communicate with to obtain consent.	○ Government photo ID ○ Proof of status ○ Proof of patient status
If the patient is deceased – all must apply.	
☐ I am the estate trustee or there is no trustee and I have assumed responsibility for the administration of the deceased patient's estate.	○ Government photo ID ○ Proof of status ○ Proof of patient status

☐	Substitute decision-maker within the meaning of section 9 the *Health Care Consent Act, 1996,* if relates to a decision about a treatment under Part II of that Act
☐	Substitute decision-maker within the meaning of section 39 the *Health Care Consent Act, 1996,* if relates to a decision about admission to a care facility under Part III of that Act
☐	Substitute decision-maker within the meaning of section 56 the *Health Care Consent Act, 1996,* if relates to a decision about personal assistance service under Part IV of that Act
☐	Guardian of person or property
☐	Attorney for personal care or property
☐	Representative appointed by the Consent and Capacity Board
☐	Spouse or partner
☐	Child, custodial parent, children's aid society
☐	Access parent
☐	Brother or sister
☐	Other relative

HERE IS WHERE YOU SIGN

First Name:	Last Name:	Middle Name(s):	
Mailing Address Where We Can Send Communications:	Contact Phone #1: Can we leave a detailed message (check)? ☐ YES ☐ NO	Contact Phone #2: Can we leave a detailed message (check)? ☐ YES ☐ NO	E-mail Where We Can Send Communications:
Signature:			Date:

INTERNAL USE ONLY

Initial	Date	
		☐ Form was completed and signed by patient/SDM and received by Windsor Family Health Team.
		☐ Form was completed by Windsor Family Health Team Representative in consultation with and signed by patient/SDM.
		☐ Form was completed by Windsor Family Health Team Representative in consultation with patient/SDM but not signed.
		☐ Directive was implemented.

The personal health information contained in this form is collected pursuant to the *Personal Health Information Protection Act, 2004* and will be used for the purposes of respecting the Directive with respect to WFHT's collection, use and disclosure of the Patient's PHI.

YOU CAN CHANGE YOUR DIRECTIVE AT ANY TIME. QUESTIONS OR NEED HELP WITH THIS FORM?
Please contact our Privacy Officer at (519) 519-250-5656 x201.

QUICK USE REFERENCE (When to use):

- **Non-Enrolled (FFS) patients – Full Consent or Consent Directive and/or Consent Directive Family/ Caregiver**
- **Enrolled Patients (FPP) Consent Directive and/or Consent Directive Family/ Caregiver**
- **Substitute Decision Makers (if patient is capable or incapable) – Full consent or Consent Directive**
- **POA Personal Care – Full Consent or Consent Directive**
- **Estate Trustee or Executor of Estate – Full Consent or Consent Directive**
- **Team Care Patients – Full Consent or Consent Directive and/or Consent Directive Family/Caregiver**