WINDSOR
Family | Health | Team

Personal Health Information Directive

Pursuant to the Personal Health Information Protection Act, 2004 (PHIPA)

This form explains your choices about how your personal health information (PHI) can be collected, used, and shared. Your rights are protected under Ontario's Personal Health Information Protection Act, 2004 (PHIPA) and the Health Care Consent Act, 1996 (HCCA). To learn more about your rights, you can visit the Information and Privacy Commissioner of Ontario at www.ipc.on.ca

Patient Name: ______________________________ **Patient D/O/B:** ________________
(Print Name of Patient) (YYYY/MM/DD)

CONSENT FOR CARE

By signing this form, I acknowledge that I understand and consent to the following:

- Express consent is required before my Personal Health Information (PHI) is disclosed outside my circle of care, such as to insurance companies, employers, or legal representatives, in accordance with the *Personal Health Information Protection Act* (PHIPA).
- My PHI may be collected, used, and disclosed among healthcare providers directly involved in my circle of care (e.g., family doctors, specialists, nurses, hospitals, laboratories) as necessary for my care and treatment. This sharing is permitted under PHIPA (ss. 18–20) through implied consent.
- Windsor Family Health Team (WFHT) may use de-identified and aggregated PHI for purposes such as statistical reporting (as required by law and funding agreements), quality improvement, planning new programs and services, and improving patient experience. No information that could reasonably identify me will ever be disclosed in these activities.
- To support clinical documentation, WFHT may use secure technology tools, including Artificial Intelligence (AI), to assist with summarizing visits. These tools do not make clinical decisions and are used solely to support accurate documentation. My health care provider will review and confirm all clinical notes for accuracy. If AI tools are used during my visit, I will be informed and my consent will be documented in my medical record.

EXCEPTIONS WHERE CONSENT IS NOT REQUIRED

I understand that in certain situations, my consent is not required by law, including:

- When necessary to prevent or reduce a serious risk of harm to someone's health or safety (*PHIPA, s.40*).
- When required by law, such as reporting communicable diseases (under the *Health Protection and Promotion Act*) or suspected abuse/neglect of children (under the *Child, Youth and Family Services Act, 2017*).
- When required by a court order, subpoena, search warrant, or an investigation by the Information and Privacy Commissioner of Ontario (PHIPA, s.43).
- When used by certain approved health organizations (called "prescribed entities") for planning, managing, evaluating, or monitoring Ontario's health system (*PHIPA, s.45*).

PLEASE READ THE FOLLOWING AND SELECT APPLICABLE OPTIONS:

☐ I am the patient and capable of making decisions regarding my Personal Health Information (PHI) pursuant to the Health Care Consent Act, 1996, Section 4.

CONSENT DIRECTIVE - *You have the right to modify or revoke your consent at any time.*

☐ **General Consent** — I consent to the collection, use, and disclosure of PHI as described above and in accordance with applicable laws.

OR

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☐ **Limited Consent -** I consent to the collection, use, and disclosure of PHI as described above and in accordance with applicable laws, with the following restrictions:

____

☐ **Delegated Consent:** I am 16 years old or older, capable of making decisions regarding my PHI, but have chosen to delegate authority to act on my behalf to a substitute decision-maker. I authorize the named person below to act on my behalf:

Name: ______________________________ **Relationship:** __________________________

☐ **Consent to Share PHI with a Designated Person -** I authorize the release of my personal health information to the individual below for the purposes selected.

Name: ______________________________ **Relationship:** __________________________

Authorized Purposes *(check all that apply)*:

☐ Schedule or cancel appointments

☐ Receive appointment reminders

☐ Pick up records or documents (with valid ID)

☐ Discuss my health information (diagnoses, medications, treatment)

☐ **Consent to Leaving a Detailed Voicemail –** I authorize WFHT to leave a detailed message on the voicemail of the primary number listed in my chart. I understand that it is my responsibility to notify WFHT of any changes to this number.

☐ **Consent to Use Your Email –** I authorize WFHT to communicate with me by email for clinically appropriate purposes, including secure messaging, clinic holiday schedules, newsletter, on-line booking or cancellations, etc. I understand that if this email is changed it is my responsibility to advise the WFHT immediately.

SIGNATURE AND PERSONAL DETAILS:

<table>
<tr><td colspan="2">First Name:</td><td colspan="2">Last Name:</td><td>Middle Name(s):</td></tr>
<tr><td>Preferred Email:</td><td colspan="2">Preferred Telephone Number:

Can we leave a detailed message at this number?
☐ Yes
☐ No</td><td>Secondary Telephone Number:

Can we leave a detailed message at this number?
☐ Yes
☐ No</td><td>Mailing Address:
____
____
____________________</td></tr>
<tr><td colspan="4">Signature:</td><td>Date:</td></tr>
</table>

For more information visit: www.windsorfht.ca to review our Privacy Policy or www.ipc.on.ca to review your privacy rights.

DOCUMENTS REQUIRED FOR ADMINISTRATIVE PURPOSES

	Document Type
Patient (16 years or older)	Government-issued photo ID