Patient Consent to Release Personal Health Information

The Ministry of Health (the "Ministry") pays for the physiotherapy services (the "Services") Lindsay Physiotherapy Services (the "Clinic") provides to you.
The Ministry conducts periodic reviews to verify the Services the Clinic provided to you and to ensure the proper use of public funds.

Your Personal Health Information

To enable the Ministry to conduct its review, the Ministry needs to collect the following personal health information from the Clinic:

1. your name
2. your date of birth
3. your Ontario Health Insurance Plan number
4. your clinical record including details of your assessment, diagnosis, treatment plan and discharge
5. the dates on which the Clinic provided Services to you

Consent for Verification Purposes

The Clinic is, therefore, asking you for your consent to allow the Ministry to collect your personal health information to assist the Ministry with its review.

Who can sign the consent form?

You can sign the consent form if:

- you are a patient of the Clinic; or
- you are a patient's "Substitute Decision Maker" authorized under *Personal Health Information Protection Act, 2004.* (See more information about what this means, below).

What does "Substitute Decision Maker" mean and who is authorized under the *Personal Health Information Protection Act, 2004* to act as the patient's Substitute Decision Maker?

If a patient does not have capacity[1] to give, withhold or withdraw consent, a Substitute Decision Maker can give, withhold or withdraw consent to the collection, use and disclosure of the patient's personal health information on behalf of the patient.

You can act as a Substitute Decision Maker for a person who does not have capacity if you have capacity and you are the highest ranked person in this list:

- a substitute decision-maker within the meaning of the Health Care Consent Act, if the collection, use or disclosure of information is connected to the decision of a substitute decision-maker about the patient's treatment;
- the guardian of the person;
- the attorney for personal care;
- the representative appointed by the Consent and Capacity Board;
- the spouse or partner;
- a child, a parent, a children's aid society or other person who is allowed by law to give or refuse consent in the place of the parent;
- a parent who has a right of access to the child;
- a sibling;
- a relative; or
- the Public Guardian and Trustee, if no other person meets the requirements.

[1] Capacity in this context means that you are able to understand the following: (1) the information on the form that explains why the Ministry wants to collect the personal health information and what they will do with that information; and (2) the consequences of giving or withholding consent.

Who can consent if the patient is under 16 years of age?

1. **The child,** so long as the child has capacity to consent,
2. **A parent of the child** (including a child with capacity), a member of the children's aid society, or another person who is legally able to consent in the place of the parent except for certain situations noted below.

A child under the age of 16 who consented to their own treatment, must decide whether to consent to the collection, use or disclosure of their personal health information related to that treatment. If a child under the age of 16 has capacity to consent and disagrees with the decision of their parent (or the person legally able to consent in place of the parent), the child's decision overrides the decision of their parent (or the person legally able to consent in place of the parent).

For clarity, there are two situations in which the parent (or other legally authorized person) cannot give consent:

1. If the personal health information relates to a treatment that a child consented to (or refused to consent);
2. If the child is capable of consenting and makes a decision about their personal health information that conflicts with the parent, or other legally authorized person's decision.

When your consent will be effective

If you give your consent to this collection by the Ministry - either as a patient, or as Substitute Decision Maker for a patient - your consent will be effective as of the date on which you sign the consent form below.

If you choose not to consent

If you choose not to consent to this collection by the Ministry:

1. the Ministry will not pay the Clinic for the Services the Clinic provides to you or the person on whose behalf you are acting as a Substitute Decision Maker; and
2. you will be required to pay the Clinic directly for the Services.

You may withdraw your consent

If you provide your consent now you may decide to withdraw it later, but please note your withdrawal will only apply going forward and will not have any retroactive effect.

Patient Consent

I consent to the Ministry of Health collecting the following personal health information about me or the patient for whom I act as a Substitute Decision Maker (as applicable) from the Clinic for the verification purposes listed above:

1. the patient's name
2. the patient's date of birth
3. the patient's Ontario Health Insurance Plan number
4. the patient's clinical record including details of their assessment, diagnosis, treatment plan and discharge
5. the dates on which the Clinic provided Services to the patient

Signature: check one ✓

☐ I am signing for myself.

☐ I am signing on behalf of _____ as a parent, or person who is lawfully entitled to give or refuse consent, on behalf of a child who is under 16.
(insert name of patient)

☐ I am signing as a Substitute Decision Maker for a person who does not have capacity. I assert that I am _____'s _____.
(insert name of patient)
(state appropriate description of the Substitute Decision Maker from the ranked list above, e.g. guardian of the person, attorney for personal care, spouse)

I understand that I can withdraw my consent by contacting Lindsay Physiotherapy Services at (705) 324-8512 and that if I withdraw my consent I will be required to pay the Clinic directly for services that the Clinic provides to me as a patient following the withdrawal of consent.

Name: _____
(please print)

Signature: _____ Date: _____
(YYYY-MM-DD)

Telephone number: _____
(if you are signing on behalf of a child or as a Substitute Decision Maker for a person who does not have capacity)

If you have questions about this consent form, please contact:

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