

Request for Audit of Consent Directive Activity

Release of Information Office Pembroke Regional Hospital T: (613) 732-3675 Ext 6142 F: (613) 732-6343 www.pemreghos.org

1. Patient Information			
First Name *	Last Name *		
Address			
DOB		СРІ	
2. Person Making the Request (ONLY COMPLETE IF YOU ARE NOT THE patient)			
First Name *	Last Name *		
Relationship to the patient*			
Address:			
3. Information being Requested			
\square List of consent instructions that you have provided and changes you made to them			
\square List of times when someone has overridden my consent instructions:			
\square All of them, or			
☐ Some of them:			
Done by a certain person (provide name and where s/he works):			
Only overrides in the past:			
☐ 3 months		☐ 3 years	
☐ 6 months		☐ 5 years	
☐ 12 months		□ AII	
Specific Date:			
From:		To:	
4. * Permission to Leave Voice Mail			
If we need to confirm information or contact you, we will call you. May we leave a message			
if you do not answer the phone?			
☐ Yes you may leave a detailed message			
☐ No you may not leave a detailed message Provide any instructions about leaving a message (e.g., only on electronic voicemail, not			
with a person if the phone is answered).			



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5. * Signature Note: The signature of both parents or proof of custody is required for children under 12
Name:
(Printed)
Date:
Parent/Guardian #2. Required for children Under 12
Name:
(Printed) Signature:
Date:
Note: The signature of both parents or proof of legal custody is required for children under
12. A certificate of Estate Trustee With a Will, A Certificate of Estate Trustee Without a Will
or a notarized Will or letter stating you are the estate trustee is required for deceased patients.
RELEASE OF INFORMATION OFFICE USE ONLY
6. Identity Confirmed
Drivers Licence □ POA □
Certificate of Estate Trustee With a Will □
Certificate of Estate Trustee Without a Will □
Other
7. Notes
Instructions to the person making the request: Return completed form to PRH Release of Information Office

Instructions to the person making the request: Return completed form to PRH Release of Information Office We will provide you with access to your personal health record, unless a legal exception applies. We will review all health record access requests, and will make every effort to respond to your request in a timely fashion. Please complete Parts A and B of this Form. Part C is for our internal use. For information about our privacy protection practices, contact the Personal Health Information Access Office at: 705 MacKay Street, Pembroke Ontario, K8A 1G8, Fax: 613-732-6343 Telephone: 613-732-3675Ext 6142

Ontario law (PHIPA) allows a healthcare provider to charge administrative fees to a person who wants a copy of his or her medical records. We may ask you to pay a fee before giving you a copy of your record.