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BOARD POLICY

Subject:	Release of Personal Health Information	Date Approved:	August 14, 2008
Approved by:	Board of Directors	Date Revised:	March 29, 2010
Specific to:	All Staff, Board of Directors and Volunteers	Next Review Date:	September 2017

POLICY

PHIPA (Personal Health Information Protection Act) is consent based legislation. Consent is considered to be knowledgeable, if the person is aware of and understands the purposes of the collection, use and disclosure (that are included on public notices posted throughout the hospitals) and are aware that they can give or withhold consent.

The record of Personal Health Information (PHI), created, acquired or maintained, regardless of the medium (verbal, written, visual or electronic) or location for a registered patient of the organization will be under the custody and control of the Health Information Custodian (HIC).
The Personal Information and Personal Health Information contained in the record is owned by the patient and must be kept confidential. (see Confidentiality Policy)

Disclosure of Personal Health Information must comply with legislative requirements (see defn), professional standards (see defn) and the procedures outlined in this policy.

DEFINITIONS

Affiliate - Individuals who are not employed by the organization but perform specific tasks at or for the organization, including physicians, students, volunteers, researchers, contractors, or contractor employees who may be members of a third-party contract or under direct contract to the organization, and individuals working at the organization, but funded though an external source

Attorney for personal care - means someone who can legally act for another person because they have a power of attorney for personal care under the Substitute Decisions Act. 1992;

Capable/Capacity - means the mental ability to make decisions for oneself.

Confidentiality - means the moral, ethical, professional and employment obligation to protect the information entrusted to individuals.

Disclose/Disclosure - under the Personal Health Information Protection Act, refers to release or making available of personal health information to another person, (other than patients or their substitute decision-makers) organization or health information custodian; it does not mean the use of the information

Express Consent - can be given either in writing, or verbally. Verbal consent must be documented.

Health Information Custodian (HIC) - means any person or organization who controls other people's personal health information as part of their role as:

- A health care practitioner or operator of a group practice of health care practitioners,

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- A service provider who provides a community service under the Long-Term Care Act,
- A community care access corporation under the Community Care Access Corporations Act,
- Some who operates one of the following facilities, programs or services;
  - A hospital under the Public Hospitals Act, a private hospital under the Private Hospitals Act, a psychiatric facility under the Mental Health Act, an institution under the Mental Hospitals Act or an independent health facility under the Independent Health Facilities Act,
  - An approved charitable home for the aged under the Charitable Institutions Act, a placement co-ordinator under the Charitable Institutions Act, a home or joint home under the Homes for the Aged and Rest Homes Act, a placement co-ordinator under the Homes for the Aged and Rest Homes Act, a nursing home under the Nursing Homes Act, a placement co-ordinator under the Nursing Homes Act or a care home under the Tenant Protection Act,
  - A pharmacy under the Drug and Pharmacies Regulation Act,
  - A laboratory or specimen collection centre under the Laboratory and Specimen Collection Centre Licensing Act,
  - An ambulance service under the Ambulance Act,
  - A home for special care under the Homes for Special Care Act, or
  - a centre, program or service for community health or mental health whose primary purpose is to provide health care,
- an evaluator under the Health Care Consent Act or an assessor under the Substitute Decisions Act,
- a medical officer of health or a board of health under the Health Protection and Promotion Act,
- the Minister or Ministry of Health and Long-Term Care, and
- any other person described as a health information custodian under the regulations to the Act (PHIPA) with custody or control of personal health information as part of performing powers, duties or work.

Health record - means the capture of Personal health information (PHI) acquired or maintained within the organization, regardless of the medium (verbal, written, visual, electronic), and is the property of the Health Information Custodian. The Personal Health Information contained in the Health Record is owned by the patient and is considered confidential.

Implied Consent - permits you to conclude from surrounding circumstances that a patient would reasonably agree to the collection, use or disclosure of the patient's personal health information.

Most Responsible Practitioner (MRP) – for the purpose of this policy the MRP may be a physician or other Regulated Health Professional who would have knowledge of the patient and the potential risks related to disclosure of the PHI.

Patient - refers to the patient who is capable with respect to the collection, use and disclosure of his or her personal health information.

Personal Health Information - The *Personal Health Information Protection Act, 2004* (“PHIPA”) defines “Personal Health Information” as:
Oral or recorded identifying information about someone that relates to:

(a) an individual's physical or mental health, or family health history, or

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(b) health care an individual receives, including who provided the health care, or
(c) a plan of service for an individual under the Long-Term Care Act, or
(d) an individual's eligibility for health care payments or the payments made for an individual's health care, or
(e) an individual's donation of any body part or bodily substance or anything derived from testing or examining a donated body part or bodily substance

Personal Health Information also includes;
(a) an individual's health number
(b) anything that identifies an individual's substitute decision -maker,
© anything that identifies an individual and that is contained in a personal health record

Personal health information **does not** include records maintained for human resources purposes.

Personal information - Information about an identifiable individual, but does not include the name, title or business address or business telephone number of a staff member of an organization.

Professional Standards – An authoritative statement that sets out the legal and professional basis of practice. Professional Standards provide an overall framework for practice. Examples of health care providers with professional standards are: College of Nurses of Ontario, the Ontario College of Social Workers and Social Service Workers and the College of Physicians and Surgeons of Ontario.

Record - means an information record in any form or media, including written, printed, photographic or electronic form, but excluding computer programs and other mechanisms that produce a record.

Substitute Decision Maker (SDM) : is defined as a person who is:
1. at least 16 years of age, unless he or she is the incapable patient's parent,
2. capable with respect to the treatment,
3. not prohibited by court order or separation agreement from having access to the incapable patient or giving or refusing consent on the incapable patient's behalf,
4. available, **and**
5. willing to assume the responsibility of giving or refusing consent.

In descending order of priority, an incapable patient's SDM may be:
a. The incapable patient's **"guardian of the person"**, appointed under the Substitute Decisions Act, 1992, if the guardian has authority to give or refuse consent to the treatment,
b. The incapable patient's **"attorney for personal care"**, given under the Substitute Decisions Act, 1992, if the power of attorney confers authority to give or refuse consent to treatment
c. The incapable patient's **"representative"** appointed by the Consent and Capacity Board, if the representative has authority to give or refuse consent to the treatment
d. The incapable patient's **spouse or partner** a **child or parent (custodial)** of the incapable patient, or a Children's Aid Society or other person who is lawfully entitled to give or refuse consent to the treatment in the place of the parent
e. **Parent (who has only a right of access)** of the incapable patient
f. **Brother or sister** of the incapable patient
g. **Any other relative** of the incapable patient
h. The **Public Guardian and Trustee**

North Perth Family Health Team
Helping you to health yourself

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Third Party Information- In relation to a patient's health record, this means personal information about an identifiable individual or individuals, other than the patient.

PROCEDURE FOR DISCLOSURE OF PERSONAL HEALTH

- A completed **Consent for Disclosure of Personal Health Information** form is mandatory for purposes other than providing health care. .
- The consent form must be signed by:
  a) The knowledgeable capable patient. Patients are presumed to be capable except if there is documented evidence available to the person making the disclosure that the patient has been found incapable of authorizing disclosure. (Note, consent has no age restriction for use or disclosure), or
  b) The Attorney for Personal Care (*see defn*), if one has been appointed by the patient, where the patient is found to be incapable, or
  c) The Substitute Decision Maker (SDM)*(see defn)* where the patient is found to be incapable, or
  d) The estate trustee, if the patient is deceased (copy of Will required) or, if there is no estate trustee , the person who has assumed this responsibility. (confirmation letter from lawyer required)
- The consent criteria for consent must include:
  - Name of the agency / institution that is to release the information;
  - Name of the individual / agency that is to receive the information;
  - Client's full name and date of birth;
  - Purpose for the disclosure of information;
  - Extent or nature of the information to be released;
  - Consent signed by client and witnessed;
  - Consent dated – information to be released is prior to the date on consent;
  - Original consent form is preferable however, a fax / electronic copy or photocopy is acceptable in urgent circumstances.
- Only the information that is specified in the consent may be released. If the entire record is requested and the appropriate consent or authorization has been received, the entire record must be provided unless the client's physician or most responsible practitioner (MRP) believes that there is some information contained in the record which could result in harm to the client.
- All information that is released must be documented, signed, and dated by the person authorized to release the information.
- Requests for information will be responded to in a timely manner. Information that is required for ongoing patient care will be provided immediately. Information that is not required for patient care will be provided within 7 -14 calendar days of receipt of the written request.
- All request to withhold information will be assessed on an individual basis and efforts will be made, to the extent possible, to comply with a client's rquest. Anyone who is asked by a client to withhold information that is routinely sent to another care provider will notify the Executive Director immediately. They will review the request and determine:
  - If the patient should be made aware of repercussions of withholding information;
  - If the request can be accommodated; and
  - If there are any ancillary reports related to the visit that can / need to be withheld (e.g. Emergency Room visit that may have laboratory or medical imaging reports as part of that visit.