SOURCE CONSENT TO DISCLOSE INDIVIDUALLY IDENTIFYING HEALTH INFORMATION FOR THE PURPOSE OF ASSESSING A BLOOD/BODY FLUID EXPOSURE

PATIENT INFORMATION ***Affix patient label here***

Patient name: _____

PHN: _____ DOB (dd/mm/yyyy): _____

Address: _____

Telephone (H): _____ (C): _____

PATIENT AUTHORIZATION

I consent to the disclosure of my individually identifying health information, including the results of any tests related to the assessment of a worker who was exposed to my blood or body fluids on _____ *(date).* This information may be disclosed by _____ *(custodian/clinic name)* to any treating healthcare provider involved in the exposed worker's care, solely for the purpose of determining the health risk and appropriate treatment, in accordance with section 34 of the *Health Information Act* (HIA).

I understand that I may revoke this consent at any time, prohibiting the CWC PCN from any further use or disclosure of my health information related to the BBFE event, and that my decision to consent is voluntary.

I understand why I have been asked to disclose my individually identifying information, and I am aware of the risks and benefits of consenting, or refusing to consent, to the disclosure of my individually identifying information.

This consent is valid until the completion of the exposed worker's treatment, unless I revoke it sooner by providing written notice by filling out a *Withdrawal of Consent to Disclose Individually Identifying Health Information for the Purpose of Assessing a Blood/Body Fluid Exposure* form, available at _____.

(clinic name and location where incident occurred)

_____ _____

Date Signature of patient or authorized representative*

*If you are signing on behalf of the patient, the following information must be provided:

_____ _____

Authorized representative name *(please print)* Print source of representative's authority [refer to HIA Section 104 (1)] *(see next page)*

_____ _____

Witness name *(please print)* Witness signature

*** Please place this form in patient's chart and provide a copy to the exposed worker in a sealed envelope marked: "Source Patient Consent Form – For Treating Healthcare Provider Only"**

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Authorized representative: Check the box that applies to you and provide a copy of documentation that supports your authority:

- ☐ The individual is under 18 years of age but does not understand the nature of the right or power and the consequences of exercising the right or power, by the guardian of the individual, [reference HIA Section 104 (1) (c)].
- ☐ A guardian or trustee has been appointed for the individual under the *Adult Guardianship and Trusteeship Act*, by the guardian or trustee if the exercise of the right or power relates to the powers and duties of the guardian or trustee, [reference HIA Section 104 (1) (e)].
- ☐ An agent has been designated under a personal directive under the *Personal Directives Act*, by the agent if the directive so authorizes, [reference HIA Section 104 (1) (f)].
- ☐ A power of attorney has been granted by the individual, by the attorney if the exercise of the right or power relates to the powers and duties conferred by the power of attorney, [reference HIA Section 104 (1) (g)].
- ☐ The individuals nearest relative as defined in the *Mental Health Act* if the exercise of the right or power is necessary to carry out the obligations of the nearest relative under that Act, [reference HIA Section 104 (1) (h)].
- ☐ Any person with written authorization from the individual to act on the individual's behalf, [reference HIA Section 104 (1) (i)].
- ☐ The individual is deceased, by the individual's personal representative if the exercise of the right or power relates to the administration of the individual's estate, [reference HIA Section 104 (1) (d)].

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