When personal health information is required from other sites or physicians, those sites or physicians may require a specific authorization from the person or their legally authorized representative, with original signatures before they will release the requested information. The study Consent form is not sufficient for this purpose as the original must remain with the study investigator and it does not specify exactly what information is wanted from the other site.

Attached is a template that can be used as a guide for a separate release of information authorization form.

Researchers at the **London Health Sciences Centre or St. Joseph's Health Care** must use the templates approved by the LHSC/SJHC Privacy Office. These can be found on the following website. http://www.lhsc.on.ca/healthrc/forms.htm

The use of a release of information authorization form **does not replace and cannot be used in lieu of** the Consent document signed by the participant when they agree to participate in the research study or clinical trial.

If a release of information authorization form is to be used:

- A copy of the form must be included in the REB submission with the other Informed Consent Documentation.
- Wording similar to the following must be included in the informed consent documentation i.e. Letter of Information.

  "In addition to the study consent form you will also be asked to sign an additional release form. This authorization will be sent to INSERT RECIPIENT(S) E.G. YOUR FAMILY DOCTOR so they can release information about your INSERT DISEASE/PROBLEM to us."

TEMPLATE FOR NON LHSC or SJHC RESEARCHERS

AUTHORIZATION TO RELEASE PERSONAL HEALTH INFORMATION

TO: INSERT NAME OF HEALTH INFORMATION CUSTODIAN I.E. INSTITUTION AND/OR PHYSICIAN
YOU ARE HEREBY REQUESTED TO PROVIDE

INSERT NAME OF STUDY PHYSICAN or designate

Of the **INSERT NAME OF STUDY PHYSICIAN'S INSTITUTION/ADDRESS E.G. LAWSON HEALTH RESEARCH INSTITUTE**

For the purposes of **INSERT TITLE OF RESEARCH STUDY/TRIAL** (UWO REB #. **INSERT #**)

To receive and inspect information from the medical record of the patient noted below and to be given copies there from in respect of, *(check all appropriate boxes)*

☐ Information regarding the patient's health, diagnosis and treatment

☐ during the period noted below

☐ related to the patient's diagnosis and treatment of ___________________________
:

☐ Clinical test results related to said patient's participation for the period noted below in the clinical trial or study referenced above.

_________________________ **TO** _________________________
Day Month Year Day Month Year

____ D.O.B. ____________________________
Print name of patient

____
Last known Address

I hereby authorize release of the Personal Health Information as described in this form.

DATED at ____________________________ this _____ day of ___________20_____
City/town/province

____
Signature of patient or legally authorized representative, stating relationship

____
Print full name and address of signatory

IN THE PRESENCE OF Signature of witness ______________________________

____
Print full name and address of witness