Ontario Ministry of Health

Request for Disclosure of Personal Claims History (PCH) Information to a Third Party

Instructions

A Personal Claims History (PCH) is a computer record of claims paid by the Ontario Health Insurance Plan (OHIP) under an individual health card number. These records are maintained for seven (7) years for billing and accounting purposes. A PCH is not a record of medical history or diagnosis. To obtain a record of the services provided by specific health care professionals, individuals should contact the provider(s) directly.

The ministry charges a $74 processing fee. A cheque for $74 made payable to the Minister of Finance must accompany this request.

Note: The **Consent Authorization Form # 5119-84E,** signed by the individual to whom this request relates, or their substitute decision maker **must** be completed in full and attached to this document upon submission.

The consent authorization form must not be collected or retained by the Third Party. Once submitted, the consent form must be securely destroyed.

Contact Information

For questions or assistance to complete this form, call CSB Inquiry Services at 1-800-262-6524.

Fields marked with an asterisk (*) are mandatory.

Section 1 – The individual whose Personal Claims History (PCH) will be disclosed under this form

Last Name *	or Single Name *	Middle Name
First Name (not applicable if Single Name entered) *	Ontario Health Card Number *	Date of Birth (yyyy/mm/dd) *

Type of Request *

☐ Full Personal Claims History (includes service dates, fee service code (FSC) and FSC description, fee paid, provider and clinic details)

☐ Limited Personal Claims History (includes service dates and provider number only)

Time Period of Request (choose one option only) *

Note: Time Period of Request must match the Time Period of Request stated on the signed Consent Authorization Form included with this submission.

PCH information is being requested for the following specific period of time that does not exceed 7 years.

☐ **Option 1**

Start Date (yyyy/mm/dd) _____ End Date (yyyy/mm/dd) _____

or

☐ **Option 2**

Start Date (yyyy/mm/dd) _____ ☐ Date request is processed

Section 2 – The Third Party that will receive the PCH directly from the Ministry of Health

Type of Third Party *

☒ Law Firm ☐ Insurance Company ☐ Government Affiliation ☐ Other (specify) _____

Name of Third Party *	File Number
Records Deposition Service	

Contact Person Name

Last Name *	First Name *
Richmond	Victoria

Contact Email Address	Contact Telephone Number *
requests@recdep.com	(248) 357-3330

Address

Unit/Suite/Apartment	Street Number *	Street Name *	Street Type
Ste. 300	29100	Northwestern	Hwy.

Street Direction	PO Box	Rural Route	General Delivery

City *	Province/State *
Southfield	MI

Postal/Zip Code *	Country *
48034	USA

Section 3 – Authority to Request (PCH) to be disclosed for the individual to whom it relates

[X] I confirm that I have obtained the necessary signed consent from the individual to whom this request relates, or their substitute decision maker **and** have attached the consent authorization form and the $74 cheque payable to the Minister of Finance with the request form. *

Important Information

Before mailing your request to the Ministry of Health, please review the form to ensure that all mandatory fields have been completed and the information is accurate. Any incomplete or inaccurate forms will be returned for correction.

Mail the completed request form to:

Ministry of Health
OHIP Personal Health Information Office
49 Place d'Armes
Kingston ON K7L 5J3

You will receive a response from the ministry within 30 days from the day the ministry receives your completed request form.

The individual's consent authorization form, once submitted, must not be retained by you and must be securely destroyed. The individual's authorized consent form includes the individual's health number. The *Personal Health Information Protection Act, 2004* prohibits the collection of a health number by non-health information custodians, subject to limited exceptions. Collecting and retaining the health number on the consent form may constitute a breach of the *Personal Health Information Protection Act, 2004.*

Important: Making a false assertion is an offence under the *Personal Health Information Protection Act, 2004.*

Ontario Ministry of Health

Consent Authorization Form: Disclosure of Personal Claims History (PCH) Information to Third Party

Instructions

The purpose of this form is to authorize the Ministry of Health to disclose your Personal Claims History (PCH) information directly to a third party named in Section 3 based on your consent. If you do not complete all mandatory parts of this form, processing may be delayed.

A Personal Claims History (PCH) is a computer record of claims paid by the Ontario Health Insurance Plan (OHIP) under an individual health card number. These records are maintained for seven (7) years for billing and accounting purposes. A PCH is not a record of medical history or diagnosis. To obtain a record of the services provided by specific health care professionals, individuals should contact the health care provider(s) directly.

Who can consent to the disclosure of PCH information to a third party?

You can consent to the disclosure of PCH information directly to a third party if you are the individual to whom the record relates or if you are the individual's "Substitute Decision Maker" authorized under the *Personal Health Information Protection Act, 2004* (see more information about what this means, including relevant information for parents, below).

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

A Substitute Decision Maker is someone who is authorized under the *Personal Health Information Protection Act, 2004* to consent on behalf of an individual to the collection, use or disclosure of personal health information about the individual. Substitute Decision Makers can consent to the disclosure of personal health information on behalf of individuals who do not have capacity to consent. You can act as a Substitute Decision Maker for a person who does not have capacity to consent to the disclosure of their own PCH if you have capacity **and** you are the highest ranked person in this list:

1. 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 individual's treatment;
2. the guardian of the person or guardian of property;
3. the attorney for personal care or attorney for property;
4. the representative appointed by the Consent and Capacity Board;
5. the spouse or partner;
6. 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;
7. a parent who has a right of access to the child;
8. a sibling;
9. a relative; or
10. the Public Guardian and Trustee, if no other person meets the requirements.

Who can consent for a child who 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 a Children's Aid Society, or another person who is legally able to consent in the place of the parent with the exception of the 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 make a PCH request and disagrees with the decision of their parent (or the person legally able to make the request in place of the parent), the child's decision overrides the decision of their parent (or the person legally able to make the request 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); or
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.

Contact Information

For questions or assistance to complete this form, call 1-800-262-6524, or visit our website at: http://www.health.gov.on.ca/en/public/programs/ohip/phi_access/default.aspx.

Once this form is completed, you must print, sign and provide the form to the Third Party named below. Do not send this form to the ministry. It is the responsibility of the third party to submit the request.

Fields marked with an asterisk (*) are mandatory.

Section 1- Type of Request

Type of Request *

[X] Full Personal Claims History (includes service dates, fee service code (FSC) and FSC description, fee paid, provider and clinic details)

[ ] Limited Personal Claims History (includes service dates and provider number only)

Time Period of Request (choose one option only) *

PCH information is being requested for the following specific period of time that does not exceed 7 years.

[ ] **Option 1**

Start Date (yyyy/mm/dd) _____ End Date (yyyy/mm/dd) _____

or

[ ] **Option 2**

Start Date (yyyy/mm/dd) _____ [ ] Date request is processed

Section 2 – The individual whose PCH will be disclosed under this form

Last Name *	or Single Name *	Middle Name
First Name (not applicable if Single Name entered) *	Ontario Health Card Number *	Date of Birth (yyyy/mm/dd) *

Address associated with Ontario Health Card *

Unit Number	Street Number *	Street Name *	PO Box
City *	Province * Ontario	Postal Code *	Country Canada

Section 3 – Authority to Request the PCH

Note: the Ministry is not responsible for any subsequent use or disclosure of the personal health information (PHI) by the Third Party.

I, _____ consent to the Ministry of Health disclosing the personal
(Last Name, First Name of person providing consent) *

claims history for _____ to
(Last Name, First Name of individual named in Section 2)

Records Deposition Service for the purpose of:
(Name of Third Party)

(Please provide purpose of consent to disclose personal claims history to a Third Party)

I have the legal authority to consent to this disclosure as I am:

Note: please select **one** of the following 4 options: *

☐ **Option 1:**
the individual whose PCH is being disclosed

☐ **Option 2:**
I am the individual's parent or other person lawfully entitled to consent on behalf of a child who is under the age of 16.

You are not entitled to consent to the disclosure of a child's personal claims history to a third party on behalf of the child if it relates to treatment provided to the child that the child consented to on their own or if the child is capable and disagrees with you consenting to the disclosure of their personal claims history to the third party.

☐ **Option 3:**
the Substitute Decision Maker for the individual whose PCH is being disclosed, who does not have capacity to consent to this disclosure.

Please indicate your relationship to the individual. See list of authorized Substitute Decision Makers included in the instructions to this form.

Relationship

_____

☐ **Option 4:**
the individual's estate trustee or individual who has assumed responsibility for the administration of the individual's estate.

Important: Making a false assertion is an offence under the *Personal Health Information Protection Act, 2004.*

The information being disclosed contains personal health information

Contact Telephone Number	Signature *	Date (yyyy/mm/dd) *