REQUEST FOR HEALTH RECORDS FOR REVIEW PANEL HEARING

Please submit your completed request to the hospital/community team or program you are requesting records from.

INSTRUCTIONS: All patient representatives, other than representatives provided by the Mental Health Law Program operated by the Community Legal Assistance Society, are required to submit this form to the facility **no later than four business days before** the scheduled reviewed panel hearing.

Part 1 Patient / Client Information

LAST NAME OF PATIENT/CLIENT	FIRST NAME	ALSO KNOWN AS / ALIAS
MAILING ADDRESS	CITY / PROVINCE / COUNTRY	POSTAL CODE
TELEPHONE NO. (INCLUDING AREA CODE)	DATE OF BIRTH DAY | MONTH | YEAR	PERSONAL HEALTH NUMBER (CARECARD)

Part 2 Records Requested

HOSPITAL / COMMUNITY TEAM or PROGRAM:

☐ HOSPITAL VISIT	DATE(S) OF RECORDS REQUESTED:
☐ COMMUNITY TEAM OR PROGRAM	DATE(S) OF RECORDS REQUESTED:

Part 3 Representative Information

NAME OF REPRESENTATIVE (LAST, FIRST)	NAME OF COMPANY OR ORGANIZATION (IF APPLICABLE)	
MAILING ADDRESS	CITY / PROVINCE / COUNTRY	POSTAL CODE
TELEPHONE NO. (INCLUDING AREA CODE)	RECORDS TO BE PICKED UP on: DAY | MONTH | YEAR	

RELATIONSHIP TO THE PATIENT/CLIENT

☐ Family member or friend of the patient

☐ A lawyer who is practicing member of the Law Society of British Columbia;

☐ Other (please indicate):_____

Part 4 Patient / Client Authorization (12 years of age or older)

I, the patient/client, hereby certify that the person named above in Part 3 is my Representative for the purpose of a Mental Health Review Board hearing.

I hereby authorize the Facility to release information from my personal health record to my representative. This consent refers only to the information requested by my Representative in Part 2, above.

By signing below, I confirm that I understand that once the requested record(s) are released to my Representative, the issuing Facility and Health Authority are not responsible for the safeguarding of the release records, or for any events caused by the releasing these records to the person named in Part 3 as my Representative.

SIGNATURE OF PATIENT/CLIENT:_____ DATE SIGNED: _____

Part 5 Representative Authorization

By signing below I confirm that I have read, understood, and agree to abide by all of the foregoing responsibilities:

☐ I, the undersigned, hereby certify that I am the Representative of the Patient at a hearing of the Mental Health Review Board ("MHRB"), on the following date: _____;

☐ I have indicated my relationship to the patient in Part 3;

☐ I am making this request solely for the purpose of representing the Patient at the hearing of the MHRB;

☐ **Reasonable limits on disclosure**. Upon receiving this request, the Facility may refuse to disclose portions of the requested record further to the MHRB Rules and Practice Directives. Exceptions include, but are not limited to: information that was obtained on a confidential basis which, if disclosed, would likely endanger the life or safety of the Patient or another person; information that would likely seriously impair the care or treatment of the Patient; and information that would identify a person who has made a report under the Adult Guardianship Act.

☐ **Documents released to this request are confidential**. As the Patient representative, you must not use a document obtained through this request for any purpose other than the specific MHRB hearing scheduled for the Patient, or by order of the MHRB. You will make all efforts to safeguard the documents disclosed pursuant to this request. Documents disclosed pursuant to this request cannot be copied or otherwise distributed, and you must not disclose the records to any person that is not the Patient, except where required by applicable law.

☐ **Confidentiality requirements continue after end of Mental Health Review Board hearing**. The requirement to keep the content of the Patient's personal health record confidential continues after the end of the Mental Health Review Boarding hearing. You are expected to securely destroy the requested records once they are no longer required (for example, by cross-shredding the records or taking them to the Facility to be shredded).

I understand that using or disclosing confidential information in a manner that is not in accordance with the above duties, or in a manner that is not necessary to fulfill my role as the Patient's Representative, is considered a breach of confidentiality and that I will be held accountable for any breaches of confidentiality and may be subject to penalty or sanction under the applicable laws.

REPRESENTATIVE FULL NAME: _____

REPRESENTATIVE SIGNATURE:_____DATE SIGNED: _____

Internal Use Only		
PATIENT/CLIENT REP SIGNATURE (on pickup)	DATE OF RELEASE	STAFF NAME

The information on this form is collected pursuant to section 25 of the Mental Health Act. It will be used to release information from the patient's personal health record to be used as evidence during a review panel hearing. Any questions you have about this form may be addressed to the director or staff of this facility.