Patient Health Information
For Tax Reporting

Practice Management Success Tip

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When patients or clients ask you for their account statement information, take the time to ask them for photo ID and a proper authorization to disclose their personal information.

Help them to understand that they can access their own information or that they can authorize you to disclose their own information to another person (a spouse, for example) **only with the patient's written authorization**. Even 'just' health care billing information is important.

Show your patients that you care about the safety of their information by taking steps to make sure we are protecting their patient and client information.

This **Practice Management Success Tip** includes

- Procedure template
- Patient Authorization form template
- Poster to quickly explain to your patients how your procedure helps to protect their privacy

It is expected that you will review and refine these documents to meet your needs.

For further assistance, contact us:

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Patient Health Information For Tax Reporting

According to the *Health Information Act,* "An individual has a right of access to any record containing health information about the individual that is in the custody or under the control of a custodian" (HIA s.7).

This means the information in a health record belongs to (and must be provided to) the patient when it is requested.

The patient may provide a written consent to a custodian to authorize disclosure of their information to another person (HIA s.34).

Review, and revise if necessary, your written policies and procedures to ensure that you have an efficient process that accurately documents these requests for access.

See the sample authorization form for the patient to complete and submit to your office.

Before releasing the information to the patient, their authorized representative, or to an authorized third party, verify their identity with photo identification before disclosing the confidential information. Don't keep a copy of their identification.

Do record that the documents were picked up by the patient or their designated representative. Do record their identity was confirmed by viewing their photo identification. A sample disclosure notation might look like this:

> "The patient's (Full Name) summary of visits from (date) to (date) including the type of service, fee charged for the service, and service provider was provided directly to the patient (or named authorized representative) on (date). The identity of the patient (or named authorized representative) was confirmed by viewing their drivers' license."
>
> [Your name, designation or position, date]

Tip: A patient may not always need to provide a written request to access their own information, but you can implement this best practice in your office to prevent errors and improve communication.

Tip: You can use a poster to quickly explain that you care about the safety of their information. You may use the poster on the next page.

Tip: Post the blank authorization form and instructions on your website so that patients can complete the form at home and bring you the complete form on their next visit.

Tip: Record a short explanation of your procedure on your office telephone system 'on hold messages'.

Access to Personal Health Information and

Disclosure of Health Information Authorization

I, ____ (Date of Birth)_______________

(Name of Patient)

authorize ____

(Name of Clinic or Organization)

to prepare a summary of **my** visits, fees, and service provider information

from: _________________________ (date)

to ____________________________ (date)

for the purpose of health / medical income tax credit or tax reporting or ___________________.

The clinic is authorized to disclose the information:

- ☐ Only to me or
- ☐ To ____

(name of recipient and their address) in accordance with section 34 the Health Information Act.

I understand that this personal health information may infer diagnostic, treatment and care information, registration information, and health services provider information and is confidential. I understand that I am responsible to keep this information safe and secure.

I understand that I make revoke my consent at any time, by providing a signed, written statement to that effect.

Date: ____________________________ Valid Until: ______________________

Signature: ________________________Print Name: _____________________

(Patient)

If you are executing this Consent as an **Authorized Representative**, you must complete the instructions on the following page.

Patient Name: ____

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

- if the individual is under 18 years of age but does not understands the nature of the right or power and the consequences of exercising the right or power, by the guardian of the individual
- if 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
- if a guardian or trustee has been appointed for the individual under the Dependent Adults 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
- if an agent has been designated under a personal directive under the Personal Directives Act, by the agent if the directive so authorizes
- if 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
- if the individual is a formal patient as defined in the Mental Health Act, by the individual's 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 the Mental Health Act
- by a person with written authorization

I understand that this personal health information may infer diagnostic, treatment and care information, registration information, and health services provider information and is confidential. I understand that I am responsible to keep this information safe and secure.

I understand that I make revoke my consent at any time, by providing a signed, written statement to that effect.

Date: ____________________________ Valid Until: ______________________

Signature: ________________________ Print Name: _____________________

(Authorized representative to ______________________________

(Patient Name, Date of Birth)

It's Tax Time!

We wouldn't share your password without your permission.

So don't ask us to share your health information without your permission.

We can provide an account summary to your tax preparer after you complete the authorization form. You can ask for an authorization form at the reception desk.

Thank you for helping us protect your privacy!

"DO YOU MIND NOT LOOKING OVER MY SHOULDER?"

Illustration from Privacy Commissioner of Canada, www.priv.gc.ca