Saskatchewan Health Authority	Standard #:	
	Title:	ROI to Physicians who request PHI related to a Client Concern initiated by the Patient or Client for release to a Third Party.
	Role performing Activity:	SHA Client Concerns Office and HIMS ROI Staff

WORK STANDARD	Location: Provincial	Department/Unit: Health Information Management
	Document Owner: Health Information Management	Date Prepared: 18-Dec-2024
	Last Revision: 12-Jan-2026	Date Approved: 03-Dec-2025
	Related Policies/Documentation: Consent for Disclosure of Personal Health Information Quality Review Request for Personal Health Information (SHA 0417)	

Work Standard Summary:

SHA Physicians can request Personal Health Information (PHI) of Patients or Clients, who were in their care, when the Physician is notified by the SHA Client Concerns Office (CCO) that a Patient or Client has contacted the SHA with a concern about the care that the Patient or Client received while in the care of that Physician. The Physician may review the PHI on their own and provide a response back to the SHA, or the Physician may involve a third-party legal counsel that will assist with the PHI review as it relates to the concern.

This work standard will provide the steps involved to allow the Health Information Management (HIM) Release of Information (ROI) team to release the PHI to the Physician in a timely manner for the purpose of releasing PHI to a Third Party.

Requests for PHI by a Physician for their own review is to follow the Quality Review – Request for Personal Health Information process.

Essential Tasks:	
1.	**SHA Client Concerns Office initiates workflow:** • Client contacts the CCO with a concern that requires a physician response. • Client can provide verbal consent for the physician to access their health record to respond to the concerns to the Client Concerns Specialist (CCS). • CCS sends email to physician regarding concerns to include the following. *"Consent from the client has been obtained to proceed with accessing the client's health records to respond to the concerns. Please follow your usual practice to access/request the health record."* • ***If the physician requires written consent***, the CCS will complete the following form and send to the physician CONSENT FOR DISCLOSURE OF PERSONAL HEALTH INFORMATION form (SHA form 0249) (see Appendix A for example). o Indicate on the form in the patient signature line "*Patient/Client verbally consented via phone on (include date and time)*" o CCS sign the form o Identify the time range based on the concern o Send the completed form to the physician • CSS documents and saves to appropriate client file

Essential Tasks:	
2.	**HIMs Process:** • ROI team receives signed “Consent for Disclosure of Personal Health Information” form from physician. • ROI team member reviews form for completeness. If information is missing, ROI team member will call the physician who sent the request to obtain the missing information. • ROI team member will process the ROI request following normal ROI workflow. • ROI team member will attach the “Physician Review – Client Concern” template letter to the ROI request ensuring the receiving Physician’s name and contact information is indicated on the letter. • ROI team member will release the PHI to the Physician.

Appendix A: Example of Completed 0249 Form (mandatory fields highlighted)

Saskatchewan Health Authority

Internal Reference MRN

CONSENT FOR DISCLOSURE OF PERSONAL HEALTH INFORMATION

Disclosure – *is the exposure of personal health information to a separate entity, not a division or branch of the trustee in custody or control of that information. An example of disclosure includes the permitted release of patient information to a third-party by the Saskatchewan Health Authority (SHA).*

The patient/client or his/her authorized representative must complete this form before the SHA may disclose the patient's/client's health information to someone else (unless Saskatchewan's *Health Information Protection Act* authorizes disclosure without consent). The information on this form, together with any record authorizing a representative to act on behalf of the patient/client, is being collected under Sections 5 and 6 or the *Health Information Protection Act* for the purpose of recording the patient's/client's consent to the specified disclosure and will be filed on the patient/client record.

Authorization:

I, Client Name, hereby authorize the SHA
(Full name of individual, guardian, or legal representative) (Program/Facility)

to release the following specified health information to Name of Physician.
(Person/Company/Agency authorized to receive health information)

Relationship to patient (if not the patient): NOK, SDM, etc.

Authorizer's Telephone Number: Home (_____) _____ - _____ Cell (_____) _____ - _____

Whose Information is Being Requested?

First and Last Name (as appears on health card)
Patient Name

Health Services Number (province of issue included)	Date of Birth (mmm-dd-yyyy)
Patient HSN	Pt DOB

Personal Health Information Requested *(If possible, please provide dates and locations where services are provided)*:

The clients health record may be accessed to respond to the concerns in the letter.

March 3-10, 2025

Address of Person/Company/Agency Authorized to Receive Health Information:

Address: _____ Town/City: _____

Province/State: _____ Country: _____ Postal or Zip Code: _____

Telephone Number: (____) _____ - _____ Fax Number: (____) _____ - _____

You will be contacted within **30 days** of the receipt of request. If the information is available, you may be charged a processing fee in accordance with the health information management fee schedule.

I authorize the SHA to disclose the health information described above to the individual(s) or organization(s) identified above. I understand why I have been asked to disclose my individually identifying information. I am aware of the risks and benefits of consenting, or refusing to consent, to the disclosure of my health information. I understand that I may revoke this consent in writing at any time.

Client verbally consented via phone on date/time
(Printed Name of applicant)

(Signature of applicant) *By typing your name above you are verifying that the information provided is true and correct.*

(Date)

- ☐ Receive copies of originals
- ☐ Pick up only
- ☐ Fax
- ☐ Mail to address above
- ☐ Examine originals with an SHA representative (*appointment required*)

Date consent is effective (mm-dd-yyyy): _____ Expiry date (mm-dd-yyyy): _____ (*valid for one year if no date*)

For administrative use only:

Received by: _____ Date received: _____
Released by: _____ Date released: _____
Verify: ☐ Government issued identification ☐ Permission to contact by telephone ☐ Permission to leave message at above telephone number
Fees waived: _____ Approved by: _____

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