Lakeridge Health

R.S. McLaughlin Durham Regional Cancer Centre

How to Request a Medical Letter or Form Completion

This handout offers information on how to request a medical letter or completion of a form by a doctor at the Durham Regional Cancer Centre (DRCC). **It is important you talk to your doctor before completing this request.** Your doctor may not complete the form if you do not meet the organization's criteria. A fee of $30 is charged by the hospital to complete your request (see #4 below). This fee is not paid to your doctor. Your doctor may charge you an additional fee as the completion of letters or forms is not covered by the Ontario Health Insurance Plan (OHIP).

To request a medical letter or form completion, you need to:

1. **Complete** the "Request for a Medical Letter or Form Completion" (page 2 of this handout). **You must sign the consent to release your health information at the bottom of page 2 for all requests**. This ensures the Release of Information Specialists has all of the information they need. Any missing information will delay your request. If you are submitting a form from another organization, make sure all consents are signed and dated.
2. **Return** the completed "Request for a Medical Letter or Form Completion" (page 2 of this handout) by:
   - ☐ Giving it to the main floor receptionist in the DRCC.
   - ☐ Faxing it to 905-721-6100.
   - ☐ Mailing it to: Lakeridge Health Oshawa, 1 Hospital Court, Room GB2-010F, Oshawa, ON, L1G 2B9.
   - ☐ Emailing to DRCC-ROI@lh.ca. E-mail is not considered a secure means of transmitting personal health information, choosing this option is at your discretion.
3. A Release of Information Specialist from LH will call to provide you with a Release ID Number after your request has been received.
4. **Pay** the $30 fee after you receive the Release ID number. This fee is in keeping with the standards set out by the Personal Health Information Protection Act. **Provide the Release ID Number** when you make your payment. It is needed to apply your payment to the right invoice.

   You can pay this fee:
   - ☐ At the LH Patient Accounts office from Monday to Friday from 8 to 4pm (except on holidays). This office is located in the main lobby of the Oshawa hospital (near the food court). Ask a volunteer for directions.
   - ☐ By credit card (Visa, MasterCard or American Express). Call 905-576-8711 extension 33203.
   - ☐ By e-transfer to accountsreceivable@lh.ca. Include the Release ID number and your name in the comment line to allow payment to be made to the right invoice.
5. Your request will be processed as soon as possible. Under the Personal Health Information Protection Act, a doctor may take up to 30 calendar days to complete your request.
6. A Release of Information Specialist will call when your letter is ready to be picked up if this is the option you chose. You need to show a receipt to pick up your letter or form.

Call a Release of Information Specialist at 905-576-8711 extension 34519 if you have any questions about a request for a medical letter or form completion.

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Request for a Medical Letter or Form Completion

Your personal information included in this request and in a medical letter or completed form is confidential. A copy of this request will be added to your hospital medical record at Lakeridge Health. Complete all sections below. **You must sign this form for all requests**. Any missing information will delay your request.

Name of patient:		Patient's date of birth: _____/_____/_____ Day Month Year
Name and phone number of person submitting request:		Patient's Health Card (OHIP) number:
Doctor(s) seen at the Durham Regional Cancer Centre (DRCC):		
Organization requesting this medical letter or form?	Name of organization:	Fax number:
	Address:	

What information needs to be included in the medical letter?

How I want to receive the medical letter or completed form (**choose only 1 option**):

- ☐ Pick it up at main reception of the DRCC. Anyone other than the patient picking it up needs to provide ID.

  _____ (name of person picking it up) _____ (relationship to patient).

- ☐ Faxed to:

  _____ (name of person/organization) _____ (fax number)

- ☐ Mailed to:

  _____ (name of person/organization)

  _____ (mailing address)

- ☐ Released to my MyChart account.

I consent to the release of my personal health information as requested above. _____ Signature of patient (or Substitute Decision Maker) _____/_____/_____ Day Month Year	Name of clerk receiving this document (print name): _____ _____/_____/_____ Day Month Year