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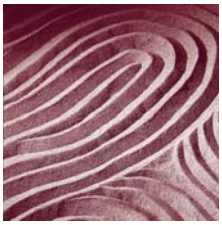

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Kathryn Frelick, "Consent and the *Personal Health information Protection Act, 2004*: Creating the Right Balance" (Paper presented to the Ontario Bar Association *First Annual Privacy Law Summit*, Toronto, 9 November 2006).

CONSENT AND THE *PERSONAL HEALTH INFORMATION PROTECTION ACT, 2004*: CREATING THE RIGHT BALANCE[*]

Introduction

The Ontario *Personal Health Information Protection Act*, 2004 (**"*PHIPA*"**) sets out requirements relating to personal health information (**"PHI"**) and the rules that govern health information custodians (**"HIC or HICs"**) when they collect, use and disclose that information.[1] The legislation, which came into force on November 1, 2004, adopts measures to ensure that an individual retains a measure of control over the collection, use and disclosure of his or her PHI, or informational self determination. Consent is a cornerstone of this legislation.

Recognizing the difficulties in applying broad based consent rules that are not designed for this sector, including the application of the federal *Personal Information Protection and Electronic Documents Act* ("**PIPEDA"**), PHIPA applies directly to the "intricacies" of PHI and is specifically applicable to the Ontario health care sector.[2] For example, the consent provisions under PIPEDA provide that the form of consent sought by an organization will depend upon the type of information. It provides that, "an organization should generally seek express consent when the information is likely to be considered sensitive".[3] PHI is almost always considered to be sensitive in nature, which has suggested the need to obtain express consent. At face value, such a requirement would surely be an insurmountable barrier to the provision of care.

Although not specifically addressed under PIPEDA, Industry Canada embraced the use of implied consent in the health care sector, relative to the exchange of PHI for health care purposes within a construct of "circle of care." The term "circle of care" does not exist within PIPEDA, however, Industry Canada defined this term as including the, "individuals and activities related to the care and treatment of a patient. Thus, it covers the health care providers who deliver care and services for the primary therapeutic benefit of the patient and it covers related activities such as laboratory work and professional or case consultations with other health care providers."[4]

Importantly, PHIPA also recognizes that HICs may rely on a patient's implied consent for disclosures of PHI to other HICs for the purposes of providing health care or assisting with the provision of care where requirements under the Act are met.[5] Further, it recognizes that specified HICs that receive PHI from an individual, substitute decision maker or another HIC for the purpose of providing health care to the individual, are entitled to *assume* implied consent for

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[1] *Personal Health Information Protection Act, 2004*, S.O. 2004, c. 3 Sched. A [cited to *PHIPA*].

[2] Information and Privacy Commissioner, *Commissioner's PHIPA Highlights*, March, 2005 at 1.

[3] 2000, Chap. 5, Schedule 1, s. 4.3.4

[4] Industry Canada, PIPEDA Awareness Raising Tools (PARTs) Initiative for the Health Sector, Questions and Answers, see question 12, online: <http://e-com.ic.gc.ca/epic/internet/inecic-ceas.nsf/en/h_gv00207e.html>

[5] PHIPA, s. 18(3)

the collection, use and disclosure of information for these purposes, unless such consent is expressly withheld[6]. Imbedded in these provisions is a construct that has developed of a "circle of care" and the recognition of the use of implied consent within this construct.

PHIPA was found to be substantially similar to PIPEDA, with the Governor General in Council issuing an Order on November 28, 2005, exempting HICs that collect, use or disclose PHI within Ontario from the application of Part I of PIPEDA. PIPEDA continues to apply to the collection, use and disclosure of PHI in the course of commercial activities, beyond provincial borders, as well as personal information that is not PHI.[7] Industry Canada clarified in its Regulatory Impact Analysis Statement that it is intended for the exemption Order to apply to agents of HICs, as well as to HICs.[8]

In summary, while PHIPA is designed to protect the confidentiality and privacy of individuals with respect to their PHI, this is within the context of "*facilitating the effective provision of health care*."[9] Thus, the legislation seeks to find an appropriate balance to ensure that individual consent obligations are met, without unduly burdening custodians and the health care system in providing appropriate health care. To this end, there are a number of activities that are permitted under PHIPA that do not require consent.

Application of PHIPA

PHIPA applies to HICs who collect, use or disclose PHI as a result of or in connection with performing the person's or organization's powers or duties. It also applies to a person who receives PHI from a HIC.[10]

PHIPA recognizes that many HICs will act through agents[11] and may permit such agents to collect, use, disclose, retain or dispose of PHI on their behalf, subject to certain exceptions.[12] For example, in the hospital setting, health care professionals including physicians, nurses and allied health professionals will be agents of the hospital for the purposes of PHIPA. In this respect, the HIC remains responsible for PHI in its custody and control, including that PHI handled by its agents.

The definition of "health information custodian" is central to the application of PHIPA and is deceptively complex. It extends to specified persons or organizations that have, "custody or control over personal health information as a result of or in connection with that person or

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[6] See for example, ss. 20(2) and 18(3), PHIPA

[7] *Canada Gazette*, Part II, Vol. 139, No. 25, December 14, 2005

[8] *Ibid.*

[9] PHIPA, s. 1(a)

[10] PHIPA, s. 7

[11] S. 2 of PHIPA defines "agent", in relation to a health information custodian, as "a person that, with the authorization of the custodian, acts for or on behalf of the custodian in respect of personal health information for the purposes of the custodian, and not the agent's own purposes, whether or not the agent has the authority to bind the custodian, whether or not the agent is employed by the custodian and whether or not the agent is being remunerated"

[12] PHIPA, s. 17(1)

organization's powers, duties or work".[13] Examples of HICs include: health care practitioners (except when acting as agent for another HIC), hospitals, community care access centres ("**CCACs**"), psychiatric facilities, long term care homes, pharmacies, laboratories, ambulance services, and others. It also includes a medical officer of health or board of health, the Ontario Minister of Health and Long-Term Care and the Ministry, "if the context so requires", and any person prescribed by regulation.[14] The Act, therefore, applies broadly, affecting individuals and organizations involved in the delivery of health care.

While most of the enumerated groups are easily defined, there are some categories of HICs that are more difficult to interpret. For example, a HIC includes, "a centre, program or service for community health or mental health whose primary purpose is the provision of health care."[15] This definition may be especially difficult for multi-service agencies that may operate more than one program. It requires careful examination of the definitions of "personal health information" and "health care"[16] and an analysis of the underlying purposes of the organization or particular activities.

Even where PHIPA does not apply to the organization at large, there may be health professionals working within the organization that are HICs (i.e. a HIC working for a non-HIC). For example, a school board may employ speech language pathologists who are HICs under the legislation in relation to their health care activities, or a large employer may operate an occupational health service. The concept of a HIC working for a non-HIC raises several concerns, including the thorny issue of employers seeking the PHI of employees. Unless authorized by law, a warrant, a collective bargaining agreement, or other limited circumstances, a HIC must obtain the express consent of the individual when disclosing PHI to an employer.

Finally, it may be difficult in some circumstances to determine whether a person or entity is a HIC in its own right or an agent of a HIC. For example, there has been some debate as to whether or not service providers under the *Long Term Care Act*, 1994 are agents of a CCAC to the extent that they are providing services through the CCAC or whether they are a HIC in this context.

These distinctions are important as they determine the roles and responsibilities of the various actors under PHIPA, and also determine how they may interact. There are different consent rules that are applicable depending upon the organization's status under PHIPA (i.e. whether consent may be implied or express; whether the sharing PHI is a use or a disclosure[17]). As such, it is essential that there is a clear understanding of an organization's status under the Act, in relation to any partner organizations or individuals.

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[13] PHIPA, s. 3(1)

[14] PHIPA, ss. 3(1)6 and 7

[15] PHIPA, s. 3(1)4.vii.

[16] The definitions of "health care" and "personal health information" are very broad. See PHIPA, s. 2

[17] S. 6(1) of PHIPA clarifies that the providing of PHI between a HIC and "an agent of the custodian is a *use* by the custodian, and not a disclosure by the person providing the information or a collection by the person to whom the information is provided"

General Rule

As a general rule, a HIC is permitted to collect, use or disclose PHI with the consent of the individual if it is necessary for a lawful purpose; *or* it may collect, use or disclose PHI without consent, as permitted or required by the Act.[18] A HIC shall not collect, use or disclose PHI if other information will serve the purpose and shall not collect, use or disclose more PHI than is reasonably necessary to meet the purpose, unless where required by law.[19]

Consent must satisfy the requirements of the Act and may be express or implied, except where the Act specifies that consent must be express.[20] While HICs have traditionally dealt with consent in relation to access and disclosure of PHI and the concept of confidentiality,[21] consent for the collection and use of PHI are newer concepts. Both federal privacy legislation and PHIPA have resulted in HICs having to change the way that they look at PHI and to address to an individual's broader privacy rights.[22]

Fundamental to the concept of consent, PHIPA recognizes the right of the individual to withhold or withdraw[23] his or her consent for the collection, use or disclosure of PHI, including for health care purposes. Further, section 20(2) of PHIPA provides that an individual can withhold or withdraw his or her consent to the collection, use or disclosure of his or her PHI by a HIC for the purpose of providing or assisting in providing health care. The so-called "lock box" provisions under PHIPA have been particularly challenging for HICs to implement, as will be discussed in more detail below.[24]

PHIPA sets out a comprehensive consent regime for HICs to follow, which includes requisite elements of consent, capacity and substitute decision making. The Act sets out those situations where a HIC may collect, use or disclose PHI without consent. Finally, there are a number of specific scenarios where PHIPA has adopted special rules for the collection, use and disclosure of PHI for particular purposes, for example, those related to fundraising and spiritual affiliation.

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[18] PHIPA, s. 29

[19] PHIPA, ss. 30(1)(2) and (3)

[20] PHIPA, s. 18

[21] Confidentiality has been described as "the obligation upon an organization or person to protect information that has been entrusted in its care for a specific purpose, and to ensure that information is only accessible to those authorized to have access".

[22] Privacy refers to the right of an individual to control who has access to his or her personal health information and under what circumstances.

[23] PHIPA, s. 19

[24] The term lock box is not a term that is used under PHIPA. See also ss. 37(1)(a), 38(1)(a) and 50 (1)(e) of PHIPA

Requirements for Valid Consent: Section 18(1)

The elements of a valid consent are set out in *PHIPA* and are applicable across any Act pursuant to which a HIC requires the consent of an individual for the collection, use or disclosure of PHI.[25] Consent must be: (a) consent of the individual (which includes his or her substitute decision maker, where applicable)[26]; (b) knowledgeable; (c) related to the information; and (d) not obtained through deception or coercion.

Consent is *knowledgeable* if it is reasonable to believe in the circumstances that the individual knows the purposes of the collection, use or disclosure, as the case may be, and that the individual may provide or withhold the consent.[27] There is an objective element to this requirement as it does not require actual belief.

Notice of Purposes

There are a number of mechanisms by which a HIC may ensure that individuals are sufficiently "knowledgable" so as to give or withhold consent the collection, use or disclosure of their PHI. For example, PHIPA recognizes that, unless it is not reasonable in the circumstances, *it is reasonable* for a HIC to believe that an individual knows the purposes for which the HIC collects, uses or discloses PHI if the custodian, "posts or makes readily available a notice describing the purposes where it is likely to come to the individual's attention or provides the individual with such a notice."[28]

The use of notice is also recognized under PIPEDA, and its adoption under PHIPA is an important communication tool, which assists in the efficient provision of care. As noted above, if a HIC wishes to rely on a notice of purposes, the notice must be posted where it is likely to come to the attention of the individual, and should include high traffic areas such as admitting and registration departments, and waiting rooms. Some organizations have opted to include such notices in their patient/resident/client handbooks or in a special brochure. The notice must outline the purposes for which the HIC collects, uses or discloses PHI. The notice should also advise the individual that he or she has the right to give or withhold consent.

The use of notice is a new concept in Ontario. After the enactment of PHIPA, stakeholders expressed concern about how much information they should include in the notice and what information should be covered. In other words, how should HICs achieve the appropriate balance to ensure that individuals are informed about the organization's information practices, but are not overwhelming individuals with too much information? The Information and Privacy Commissioner/Ontario ("**IPC**") similarly expressed concern about notices being overly lengthy or complicated. The IPC noted that research performed in the United States, for example, had

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[25] PHIPA, s. 18(1)

[26] S. 2 under PHIPA defines "individual", in relation to personal health information, as "the individual, whether living or deceased, with respect to whom the information was or is being collected or created"

[27] PHIPA, s. 18(5)

[28] PHIPA, s. 18(6)

demonstrated that members of the general public are usually irritated and repelled by excessively detailed posters and pamphlets[29].

To address these concerns, a Short Notices Committee consisting of representative from the Ontario Bar Association – Privacy and Health Law Groups, the Ministry of Health and Long Term Care, the Ontario Dental Association and the IPC was established to develop notices for the health sector. Three posters were developed entitled, *In Our Hospital*; *In Our Facility* and *In Our Office*. Accompanying the posters are brochures containing more information should a client wish to learn more. Finally, the committee recommended a three tiered approach to providing information about privacy as being the most effective method of communicating with clients, including:

i) a short and compelling poster;

ii) a pamphlet with additional information; and

iii) a detailed discussion with the person who is making the enquiry.[30]

It is recognized that all of these steps are not required in all instances. In many cases, the notice itself will be sufficient. Many HICs have customized their own forms to address their specific needs, for example, where an organization is part of a shared electronic health system or employs particular information practices.

In circumstances where a HIC may assume implied consent, it is not necessary to rely on a notice of purposes. Nevertheless, it is considered a best practice to utilize such notices, and to promote openness and transparency of privacy practices.

Forms of Consent

Under PHIPA, consent for the collection, use or disclosure of PHI about an individual may be express or implied, except where the Act requires that such consent must be express.[31] The terms "express" and "implied" are not defined under PHIPA, however, express consent is taken to mean consent which is explicitly sought by and provided to the HIC, either orally or in writing. Such consent is unequivocal and does not require any inference on the part of the custodian. In contrast, implied consent is consent given to a HIC implicitly. In other words, a HIC can reasonably imply, based on an individual's action or inaction in particular circumstances, that consent has been given or refused.

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[29] IPC – Short Notices to the Public under the *Personal Health Information Protection Act, 2004* <<www.ipc.on.ca/scripts/index_.asp?action=31&P_ID=16233&N_ID=1&PT_ID=15841&U_ID=0>>

[30] *Ibid.*

[31] PHIPA, ss. 18(2) and (3)

The use of "opt out" or "negative" consent, by which individuals are given the opportunity to be removed from selected or all contacts with organization also has some limited application under PHIPA, for example, in relation to fundraising.[32] In these circumstances, unless individual takes action to opt out or say no, the custodian can assume that it has consent to proceed.

Where Consent must be Express

PHIPA sets out when express consent is required. For example, consent to the disclosure of PHI to a person who is not a HIC must be express. Thus, disclosures of PHI to third parties, such as lawyers, insurance companies, or police generally require express consent unless PHIPA permits the disclosure without consent or provides that implied consent is permitted. Consent must also be express where a HIC discloses PHI to another HIC, if this is done for a purpose other than providing health care or assisting in providing health care.[33] If the collection, use or disclosure of PHI is for marketing or market research purposes, then consent must be express.[34] Finally, when collecting, using, or disclosing PHI for fundraising activities, a HIC may imply consent, but only if the consent relates to an individual's name and certain types of contact information.[35] Otherwise, for additional information to be disclosed, consent must be express.[36]

Express consent is the strongest form of consent since it is unequivocal. Even where other forms of consent are permitted, a HIC may, at its discretion, rely upon the express consent of an individual for the collection, use or disclosure of PHI in the custody or control of the HIC[37].

Where Consent may be Implied – For Health Care Purposes

HICs may rely on a patient's implied consent for disclosures of PHI as between themselves, provided that the requirements for consent are fulfilled and the information is being disclosed for the purposes of health care or assisting in the provision of health care.[38] This extends to any category of HIC under the Act.

As a subset of this, PHIPA recognizes that certain categories of HICs who receive PHI about an individual from another custodian, the individual or the individual's substitute decision maker are *"entitled to assume"* that they have implied consent for the collection, use and disclosure of PHI for the purposes of providing health care or assisting in the provision of health care.[39] This is subject to the situation where the HIC who receives the PHI is aware that the individual has expressly withheld or withdrawn their consent. In this event, the HIC must either obtain the individual's express consent for the collection, use or disclosure of PHI, as the case may be, or alternatively, be subject to those instructions.

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[32] See Regulation 329/04 made under PHIPA, s. 10

[33] PHIPA, s. 18(3)

[34] PHIPA, s. 33

[35] PHIPA, s. 32(1)(b)

[36] PHIPA, s. 32(1)(a)

[37] PHIPA, s. 6(3)(c)

[38] PHIPA, s. 18(3)

[39] PHIPA, s. 20(2)

HICs who are entitled to rely upon an assumption of implied consent in these circumstances are generally those health providers who are directly involved in the provision of care.[40] They do not include, for example, the Ontario Ministry of Health and Long Term Care or Medical Officer of Health. Notwithstanding that these latter categories of HICs cannot *assume* implied consent; they may still rely upon implied consent in appropriate circumstances, where it is reasonable to do so.[41]

Those HICs who are entitled to assume the individual's implied consent for the collection, use and disclosure of PHI for health care purposes are sometimes referred to as the "circle of care". This is not a defined term under PHIPA, and as such, it can be used differently by different individuals and organizations. The *Hospital Privacy Toolkit* describes it as follows:

> The term "circle of care" describes those "…individuals and entities such as health professionals, laboratories, hospitals, pharmacies" etc. "…who provide health care or assist in providing health care to a particular patient. Members of a particular patient's "circle of care" can provide health care to the patient, confidently assuming that they have consent to collect, use and disclose the patient's personal health information for that care, unless they know that the patient has expressly withheld or withdrawn consent."[42]

In this regard, the circle of care is defined for each specific patient and does not automatically include people who are not involved in the care of the specific patient at the time. For example, it can be assumed that when a patient accepts a referral to, or care, diagnosis or treatment from a specific agency or health practitioner, that patient is in fact providing implied consent for the collection, use and disclosure of their PHI.

Since the term may have different interpretations, where an individual HIC uses the term "circle of care" it is prudent to define it appropriately so that it can be used consistently throughout the organization. In any event, it must be consistent with the provisions of PHIPA and as such, it is better to rely upon the actual language of the Act, where possible.

Implied Consent for Non-Health Care Purposes

PHIPA sets out other situations where implied consent may be used for non-health care related purposes. For example, fundraising activities are critical to the continued operation and capital development of many health care institutions, such as hospitals, and these organizations depend upon patients as part of their donor base. This important relationship has been recognized under PHIPA and special rules developed for the sharing of specific types of information for fundraising purposes. Similarly, many HICs rely upon external spiritual advisors to support clients and their families during times of ill health. PHIPA also addresses the important role of these services.

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[40] PHIPA, s. 3(1). S. 20(2) applies to those HICs described in paragraphs 1, 2, 3 or 4 of the definition in s. 3(1)

[41] H. Perun, M. Orr & F. Dimitriadis, Guide to the Ontario Personal Health Information Protection Act (Toronto: Irwin Law Inc., 2005) at 214.

[42] *Hospital Privacy Toolkit: Guide to the Ontario Personal Health Information Protection Act*, (Ontario Hospital Association, Ontario Hospital e-Health Council, Ontario Medical Association, Office of the Information and Privacy Commissioner/Ontario and Queen's Printer for Ontario, September 2004) at page 52

Spiritual Affiliation

The provision of PHI to external clergy members is a disclosure. PHIPA contemplates that a HIC that is a facility may rely upon implied consent of the individual in order to disclose limited PHI to "a representative of a religious or other organization", provided a number of conditions are met. Section 20(4) of PHIPA provides that where a patient or resident provides information about his or her religious or other organizational affiliation, the facility is entitled to assume that it has the individual's implied consent to provide his or her name and location in the facility to a representative of that organization. This is the only information that may be provided, however, in order to do so, the HIC must first have offered the individual the opportunity to withhold or withdraw his or her consent.[43]

This situation may be distinguished from the case where the facility's health care team includes those who provide spritual care, and who are acting as agents of the HIC for the purposes of PHIPA. In these situations, PHI may be shared with the individual, as appropriate to his or her duties, and such sharing of information is considered to be a use and not a disclosure. Involvement by members of the spiritual care team may be triggered by a referral from another member of the health care team, or through a patient or resident request for spiritual services.

Fundraising

As outlined above, a HIC may collect, use or disclose PHI about an individual for the purpose of fundraising activities where the individual expressly consents; or the individual consents by way of an implied consent and the information consists only of the individual's or substitute decision maker's name and mailing address, subject to prescribed requirements.[44]

Section 10 of Regulation 329/04 made under PHIPA sets out the circumstances upon which a HIC may rely upon implied consent in order to disclose PHI for fundraising purposes. A HIC may only be collect, use or disclose PHI for the purpose of fundraising activities undertaken for a charitable or philanthropic purpose related to the HIC's operations.

Further, consent under PHIPA may only be inferred where the following conditions are met:

- the HIC has provided a notice or statement to the individual at the time of providing service, that unless he or she requests otherwise, the individual's name and contact information may be disclosed and used for fundraising purposes on behalf of the HIC, together with information on how the individual can easily opt-out of receiving any future fundraising solicitations; and
- the individual has not opted out within 60 days
- all solicitations for fundraising must provide the individual with an easy way to opt-out of receiving future solicitations

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[43] PHIPA, s. 20(4)

[44] PHIPA, ss. 32(1) and (2)

- communications from the custodian or fundraiser must not include any information about the individual's health care or state of health

Section 18(7) and Section 20(1): The Assumptions Related to the Validity of Consent

Assumption: Consent Valid

Where a HIC has obtained or a document or has received one purporting to record consent to the collection, use or disclosure of PHI, a HIC is *entitled to assume* that the consent fulfills the requirements of *PHIPA*, and the individual has not withdrawn consent. The assumption, however, cannot be relied upon in circumstances where it is not reasonable to do so.[45]

From a practical perspective, this provision is very important as it allows HICs to proceed on the basis of consent, without the necessity of "proving" that the information is valid. For example, where an individual has requested in writing that his or her PHI be provided to a third party, and has provided a signed authorization to that effect, the HIC is entitled to rely upon that document, unless there is information that would suggest it is not valid.

Finally, consent to the collection, use or disclosure of PHI that has been given prior to November 1, 2004 is valid if it meets the requirements for consent under PHIPA.[46]

Withdrawal, Limitation or Conditional Consent

Provisions relating to the withdrawal, limitation or placement of conditions or restrictions on consent for the collection, use and disclosure of PHI for health care purposes are a departure for many HICs. Where an individual has provided consent to the collection, use or disclosure of his or her PHI, he or she is entitled to withdraw this consent at any time, by providing notice to the HIC. The withdrawal of the consent does not have retroactive effect, that is, it is only effective as of the time it is received.[47]

In addition, an individual may place restrictions on their consent. For example, a patient may permit information to be shared only with a specific organization or for a specific purpose. Importantly, even where an individual places conditions on his or her consent to have a HIC collect, use or disclose PHI, the legislation recognizes the need for a HIC to record this PHI in accordance with legal obligations, established standards of professional practice or institutional standards.[48] Thus, a health professional is obligated to maintain a complete record of PHI, which must be maintained in a manner that complies with the legislation and professional standards.

The Act requires that where a HIC does not have the consent of the individual to disclose all of the PHI about the individual that is reasonably necessary for the provision of health care to another HIC, that the other custodian must be notified of that fact.[49] Especially in cases where there is concern that there is not sufficient information for appropriate provision of care, it is

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[45] PHIPA, s. 20(1)

[46] PHIPA, s. 18(7)

[47] PHIPA, s. 19(1)

[48] PHIPA, s. 19(2)

[49] PHIPA, s. 20(3)

essential for HICs to have an effective process to manage these situations and to ensure that the individual is fully apprised of the effect of the withdrawal or condition and potential risks. The discussion should be carefully documented in the patient's record of PHI.

Capacity and Substitute Decision Making under *PHIPA*

Capacity to Consent

Under PHIPA, an individual is presumed to be capable of consenting to the collection, use or disclosure of PHI unless there are reasonable grounds to believe that the individual is incapable.[50] Specifically, section 21(1) under PHIPA provides that an individual is capable if he or she is:

(a) *able* to understand the information that is relevant to deciding whether to consent to the collection, use or disclosure, as the case may be; and

(b) *able* to appreciate the reasonably foreseeable consequences of giving, not giving, withholding or withdrawing the consent. [Emphasis added]

Case law interpreting the use of the term "capacity" under the *Health Care Consent Act*, *1996* (**"HCCA"**) in the treatment context has held that it the *ability* to understand and appreciate that is important in making this determination, rather than actual understanding or appreciation.[51] While courts have not examined the definition of capacity under PHIPA, given the similarities in the language, it is suggested that this body of case law would be instructive for HICs making this determination.

PHIPA provides that capacity may fluctuate depending upon the type of information and time that consent is sought.[52] Thus, it is important to consider the particular circumstances when making a determination of capacity.

Where an individual is found to be incapable with respect to consenting to the collection, use or disclosure of his or her PHI, he or she must be informed of the finding and the consequences of the determination.[53] The individual may appeal the finding of incapacity to the Consent and Capacity Board.

Persons Authorized to Act as Substitute Decision Makers for Capable Individuals

Unlike the HCCA, which does not permit a capable person to "delegate" their decision making authority, capable individuals who are sixteen years old or older may provide consent directly or may authorize in writing any capable person sixteen years of age or older to provide consent for the collection, use or disclosure of PHI on his or her behalf.[54] Formerly, the *Mental Health Act*

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[50] PHIPA, ss. 21(4) and (5)

[51] See for example, the Supreme Court of Canada decision in *Starson* v. *Swayze* [2003] S.C.R. 722

[52] PHIPA, ss. 21(2) and (3)

[53] PHIPA, s. 22(2)

[54] PHIPA, s. 21(4)

had recognized the ability to designate a representative to make informational decisions, and with the enactment of PHIPA, this has been given broad application across the health sector.

In order to rely upon this provision, both the individual and the designate must be determined by the HIC to have capacity to make the particular decision. From a risk management perspective, it is suggested that the HIC verify the individual's written authorization to ensure that it gives the decision maker the requisite authority to make the particular decision, request or give an instruction on behalf of the capable individual. The terms of the authorization must comply with the obligations under the Act.

Persons Authorized to Act as Substitute Decision Makers for Incapable Individuals

Where a person has been found to be incapable with respect to informational decision making, PHIPA sets out, in order of priority, those persons who may exercise substitute decision-making authority on the individual's behalf.[55] Before a HIC may resort to the hierarchy of decision-makers, however, the HIC must determine if the incapable person has a substitute-decision maker under the HCCA.[56]

Where an individual has a substitute decision maker under treatment, admission to a care facility and/or a personal assistance service under the HCCA, that person is deemed to be the substitute decision maker of the patient in relation to the collection, use, or disclosure of PHI that is necessary for or ancillary a decision under the HCCA.[57] If this is the case, this individual ranks above any other person.

If the incapable patient does not have a substitute decision maker authorized to make decisions under the HCCA, or where the decision does not relate to a decision under the HCCA, a HIC must refer to the list of substitute decision makers under the Act. Similar to the hierarchy set out in the HCCA, the following individuals may give, withdraw, or withhold consent on behalf of an incapable individual[58] and must do so in accordance with the principles for decision making set out in the Act[59]:

- The individual's guardian of the person or guardian of property, if the consent relates to the guardian's authority to make a decision on behalf of the individual.
- The individual's attorney for personal care or attorney for property, if the consent relates to the attorney's authority to make a decision on behalf of the individual.
- The individual's representative appointed by the Consent and Capacity Board under section 27, if the representative has authority to give the consent.
- The individual's spouse or partner.

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[55] PHIPA, s. 23(1)(3)

[56] PHIPA, s. 26(11)

[57] PHIPA, ss. 5(2), (3) or (4)

[58] PHIPA, s. 26

[59] PHIPA, s. 24

- A child or parent of the individual, or a children's aid society or other person who is lawfully entitled to give or refuse consent in the place of the parent. This paragraph does not include a parent who has only a right of access to the individual. If a children's aid society or other person is lawfully entitled to consent in the place of the parent, this paragraph does not include the parent.

- A parent of the individual with only a right of access to the individual.

- A brother or sister of the individual.

- Any other relative of the individual.

Section 26(6) sets out that, as a last resort, if no person falls under a description set out in s. 26(1), then a decision can be made by the Public Guardian and Trustee.

Children

There is no minimum age of consent under PHIPA. As a result, if a child meets the test for capacity, he or she is entitled to make his or her own decisions with respect to the collection, use or disclosure of PHI.

If the child is over the age of sixteen, then those provisions that are applicable to any individual apply equally to the child. In other words, a child who is capable and aged sixteen years or older may consent on his or her own behalf or may authorize another capable person who is at least sixteen years of age to provide consent in his or her place.[60]

If a child is capable and less than sixteen years old, a custodial parent, a Children's Aid Society, or a person lawfully entitled to stand in the place of a parent may *also* consent the collection, use or disclosure of PHI on the child's behalf, as may the child. Such persons cannot exercise this authority if the PHI relates to treatment about which the child has made a decision on his or her own pursuant to the HCCA or counselling in which the child has participated under the *Child and Family Services Act.*[61]

Finally, if the child is capable and less than 16 years of age, and there is a person who is entitled to act as the substitute decision-maker as set out above, a decision of the child prevails over that person in the event of a conflict. Thus, both the child and the substitute decision-maker may potentially be involved in the particular decision, however, ultimately, the child's decision must be complied with.[62]

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[60] PHIPA, s. 23(1)1

[61] PHIPA, s. 23(1)2i. and ii.

[62] PHIPA, s. 23(3)

Deceased Persons

Consent for deceased individuals for the collection, use or disclosure of information of PHI may be provided by the deceased's estate trustee. If there is no estate trustee, the person who has assumed responsibility for the administration of the estate may give or refuse consent.[63]

Where the deceased individual had a will or where it is necessary to probate an estate, it can be expected that there is documentation relating to the appointment of an estate trustee. Where possible, a HIC should verify the authority of the estate trustee by obtaining a notarized copy of the will, a "Certificate of Appointment with a Will" or a "Certificate of Appointment of Estate Trustee without a Will" for its records. Where the HIC is obtaining consent from a "person who has assumed responsibility for the administration of the deceased's estate", a HIC may obtain consent from this individual if it is reasonable for to rely on the accuracy of the assertion made by that person, regarding their identity.[64] Depending upon the circumstances, some HICs may request additional documentation to support this contention, such as a notarized letter from the individual stating that he or she has assumed this responsibility and has no knowledge of any other individual who is or may claim to be the estate trustee of the individual.

Relying on the Assertions of Those who Claim Authority to Consent

PHIPA permits a HIC to rely upon the assertions of a person who claims authority to give consent under the Act "unless it is not reasonable to do so in the circumstances"[65]. A HIC may rely upon the assertion of another person that consent is granted with respect to access to, or the collection, use or disclosure of PHI, and specifically that:

- The person is entitled to consent to the collection, use or disclosure of PHI for that individual;
- The person is over the age of sixteen;
- The person is not prohibited by a court order or separation agreement from having access to the individual;
- No other person ranked higher or equally exists or if they exist, they would not object to the person making the decision.

Notwithstanding the above, where authority is derived pursuant to a legal document, it is prudent for a HIC to request a copy of the document for its records. Furthermore, a HIC may also ask questions to establish the individual's authority and document the answers provided. Where there is a question about the individual's authority, a HIC must make reasonable efforts to determine the appropriate substitute decision maker before taking action on those instructions.

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[63] PHIPA, s. 23(4)

[64] PHIPA, s. 20(1)

[65] PHIPA. s. 71(4)

Withdrawal of Consent and Express Instructions

What does "Lock-Box" Mean?

The term "lock-box" is not defined under PHIPA, however, it refers to the *qualified* right of an individual to withhold or withdraw their consent to the collection, use or disclosure of PHI, including for health care purposes[66]or the *qualified* right to provide an express instruction not to use or disclose PHI for health care purposes without the individual's express consent.[67]

PHIPA recognizes that in some circumstances a HIC may need to collect, use or disclose PHI for health care purposes without consent. The lock-box provisions provide an exception to these exceptions. Section 37(1)(a), for example, provides that a HIC, "may use PHI about an individual for the purpose for which the information was collected or created and for all the functions reasonably necessary for carrying out that purpose, *but not if the information was collected with the consent of the individual or under s. 36(1)(b) [indirect collection] and the individual expressly instructs otherwise*." In these circumstances, the HIC may only use the information as specified, unless it obtains the express consent of the individual.

Similarly, under s. 38(1)(a), a HIC may disclose PHI about an individual to certain HICs without consent, "if the disclosure is reasonably necessary for the provision of health care and it is not reasonably possible to obtain the individual's consent in a timely manner". Again there is an exception if the individual has expressly instructed the custodian not to make the dislosure."[68]

Finally, section 50(1)(e) allows a HIC to disclose an individual's PHI to a person outside of Ontario if the disclosure is reasonably necessary for the provision of health care to the individual. If the individual has expressly instructed the HIC not to make the disclosure, the HIC is prohibited from doing so.

In practical terms, the ability to "lock" PHI may translate into an individual's request that a HIC not collect, use or disclose a particular item of information contained in their health record (for example, a particular diagnosis), a particular part of a record or the entire contents of the health record. An individual may request that PHI not be used by certain members of the health care team or classes of health professional or disclosed to another custodian, health professional (i.e. family physician) or type of health professional or agent.[69]

As indicated above, the ability to lock PHI is qualified, that is, an individual cannot rely on the lockbox provisions where another provision under PHIPA requires or permits the collection, use or disclosure of PHI without consent, for example:

- A HIC may use PHI where consent is not required, for example, risk management or research purposes, to find a substitute decision-maker or to verify the eligibility of a patient for provincially funded health insurance

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[66] PHIPA, s. 20(2)

[67] PHIPA, ss. 37(1)(a), 38(1)(a) and 50(1)(c)

[68] PHIPA at s. 38(1)(a)

[69] Information and Privacy Commissioner/Ontario, *Fact Sheet* Number 8 - Lock Box, July 2005

- A HIC must comply with mandatory reporting requirements, such as reporting a child in need of protection under the *Child and Family Services Act* and reporting communicable and reportable diseases under the *Health Protection and Promotion Act*

- An express instruction may be overridden if a custodian believes on reasonable grounds that disclosure of PHI is necessary for the purpose of eliminating or reducing a significant risk of serious bodily harm to a person or group of persons[70]

- A HIC must notify another health care provider to whom the individual's PHI has been disclosed where it is believed that the individual has not consented to the disclosure of all PHI that is reasonably necessary for the provision of care to the individual. Where this is the case, the recipient custodian may follow up with the individual to seek express consent[71]

There may be occasions where a HIC believes that the individual cannot be treated safely due to insufficient information. In the interests of patient safety, for example, the College of Physicians and Surgeons of Ontario recognizes that a physician may refuse to treat a patient based on lack of information, but only in non-emergency situations.[72] It is incumbent upon a custodian to ensure that the individual is aware of the risks associated with "locking" PHI and that this may have an adverse impact upon the quality of care provided.

Duties Arising from "Lock Box" Requests

Lock box requests are one of the most challenging aspects of PHIPA for many HICs, particularly in the realm of electronic health records. Technology has outpaced regulatory efforts, with the effect that many HICs lack the technical ability to effectively manage requests to withdraw, withhold or restrict PHI. Nevertheless, the lock box provisions of PHIPA are fully operational and HICs must comply with requests made, subject to their technical and logistical limitations.

The IPC has suggested that compliance with the lock-box provisions can be achieved through:

- Policies, procedures or manual processes;

- Electronic or technological means; or

- A combination of policies, procedures or manual processes and technological means.[73]

There are a number of strategies that a HIC may employ to implement lock box requests and to manage the risk. For example, a HIC would be well advised to ensure that any requests to withhold, withdraw or restrict the collection, use or disclosure of PHI be made in writing. Where there are significant restrictions, there should be a process to explore the reasons for the request, discuss the implications and risks associated with such a decision, the limitations of the lock-box provisions, as well as logistical or technical implications of the provider in managing the request

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[70] PHIPA, s. 40

[71] PHIPA, s. 20(3)

[72] The College of Physicians and Surgeons of Ontario, *Confidentiality of Personal Health Information,* Policy #8-05

[73] *Supra*, note 60 at 3.

(i.e. need to manually separate the record or need to place confidentiality flags and/or monitor access). A waiver or release setting out this information may also be obtained from the individual.

Some HICs convene a specially devised review team to assess potential risks associated with locking a patient's health record. This is followed by a meeting with the individual to review the risk assessment and the manner in which paper and/or electronic health records may be managed to accommodate the request.

'Lock-Box' Case Study: Order HO-002

In July of 2006, the IPC released its second order relative to PHIPA which sheds light on several issues, including the lock-box provisions under PHIPA and responsibilities that a HIC has relative to its agents[74]. In this case, a patient made a complaint to the IPC with respect to unauthorized access to her hospital electronic health record ("**EHR**").

The IPC investigation found that at the time of her admission, the patient had informed hospital staff that she did not wish her estranged husband, an employee of the hospital, or his girlfriend, who worked there as a nurse, to be aware of her hospitalization or to access her PHI. The patient was in the midst of divorce proceedings, and following her discharge, she learned through conversations with her estranged husband that details of her treatment had been disclosed. The patient filed a complaint with the hospital.

Upon receiving the complaint, the hospital took immediate steps to "flag" the patient's EHR and conducted an audit of all access to her record. The audit confirmed that the nurse in question had inappropriately accessed the patient's record. Despite the confidentiality flag on the patient's EHR, and the ongoing investigation, it was discovered that the nurse inappropriately accessed the patient's EHR on three further occasions after the patient had complained to the hospital.

The IPC found that the hospital failed to take reasonable steps to safeguard the patient's PHI. Despite the fact that the nurse blatantly disregarded the hospital's policies, she was nonetheless an agent of the hospital, and as such, it had an obligation to ensure that the patient's PHI was protected.[75] The IPC commented that the agency provisions under PHIPA, "would be rendered meaningless if a person who would usually be an agent is converted to a non-agent in the event that they act improperly".[76]

With respect to the hospital's lock-box requirements, after the patient complained to the hospital's privacy officer, a "VIP flag" was placed on the patient's EHR which notified those accessing the computer records that access to the file was being monitored. While not preventing access to be made, these types of flags are designed to ensure that any privacy breaches can be quickly identified and dealt with.[77] The IPC recognized that the "VIP flag" system, which notifies users of potential privacy breaches, is an acceptable practice and meets the controls necessary to ensure respect for the 'lock-box' provisions. The IPC further observed

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[74] Information and Privacy Commissioner/Ontario, Order HO-002, July 2006

[75] *Ibid.* at 6

[76] *Ibid.* at 6

[77] *Ibid* at 13

that "the rationale for not incorporating stricter access controls into clinical information systems that are typically used in hospitals is that if relevant information is not readily available in an emergency situation, this could pose a risk to a patient's health and safety."[78]

Having said this, these types of mechanisms must be used in conjunction with appropriate policies and procedures, including a privacy breach protocol that coordinates the privacy and human resources components of the investigation. The IPC stated that while human resources protocols are important, patient privacy is the paramount consideration.[79]

Collecting, Using, and Disclosing Personal Health Information without Consent

As stated above, the general principle under PHIPA provides that PHI may only be collected, used or disclosed with the consent of the individual, or as permitted or required under the Act. PHIPA was not intended to replace all existing legislation with respect to the use and disclosure of PHI, and for the most part, preserves, updates and broadens the application of such provisions so that they are applied consistently within the health sector. Furthermore, the legislation recognizes that there are situations where obtaining consent for the collection, use or disclosure of PHI may not be possible or appropriate and it adopts special provisions, where, for public policy reasons, such activities do not require consent.

Where a provision allowing disclosure under PHIPA is permissive, a HIC is not required to disclose the PHI unless required to do so by law; nor is the HIC relieved from a legal requirement to disclose the information.[80] Finally, it does not prevent the HIC from obtaining the individual's consent for the disclosure[81] and there are many reasons why a custodian, for policy reasons may set its own internal rules with respect to different types of PHI. For example, a psychiatric facility may develop more stringent requirements for disclosure of sensitive PHI than required under the Act.

Permissible Forms of Indirect Information Collection without Consent

PHIPA sets out those circumstances where a HIC may collect information about an individual from a source other than the person to whom the information relates. For example, indirect collection of PHI without consent is permitted if such information is reasonably necessary for the provision of health care, and it is not reasonably possible to collect PHI the information directly from the patient.[82] This may be because the information cannot be relied on as accurate,[83] for example, where the individual is disoriented or confused or suffering from a mental disorder which affects his or her perception. Secondly, a HIC may need to collect information from other sources where the information cannot be obtained directly from the individual "in a timely

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[78] *Ibid.* at 14

[79] *Ibid.* at 15

[80] PHIPA, ss. 6(3)(a) and (b)

[81] PHIPA, s. 6(3)(c)

[82] PHIPA, s. 36(1)(b)

[83] PHIPA, s. 36(1)(b)(i)

manner",[84] for example, where an individual is unconscious and a substitute decision maker cannot be located.

There are other examples of indirect collection of PHI, for example, by a HIC that is an institution under the *Freedom of Information and Protection of Privacy Act* or *Municipal Freedom of Information and Protection of Privacy Act*, for the purposes of conducting a proceeding, investigating a breach of agreement or law, or its statutory function.[85] In addition, HIC may collect PHI from a person who is not a HIC where the custodian is carrying out research.[86] There are also situations where PHI is collected from a person who is permitted or required by law to disclose it to the HIC, for example, information forming the basis for a Form 1, Application for Psychiatric Assessment under the *Mental Health Act* may come from a number of different sources.[87] Finally, a HIC may be permitted or required by law to collect the PHI indirectly, for example, the medical officer of health, as a HIC, is required to collect PHI under the *Health Protection and Promotion Act* relative to communicable and reportable diseases.[88]

Permitted Uses without Consent

PHIPA authorizes a HIC to use PHI that it is collected for health care purposes and for specified secondary purposes, where it would not be practicable or reasonable to seek permission from the individual or the use is consistent with certain public policy goals.[89] Section 37(1)(a) provides that a HIC may use PHI without consent of the individual, "for the purpose for which the personal health information was collected or created", and "for all functions reasonably necessary for carrying out that purpose", subject to any express instructions to the contrary.

There are a number of secondary purposes for which use of PHI is permitted without consent, including: the planning or delivery of health programs or services[90], obtaining payment, processing, monitoring, verifying or reimbursing claims for payment,[91] and risk or error management to improve or maintain the quality of programs or services.[92] Use of PHI for the "purpose of educating agents to provide health care[93], and for use in a legal proceeding or contemplated proceeding in which the HIC or agent is a party or witness are also permitted[94]. PHI may also be used for research purposes, provided that the HIC has fulfilled the requirements

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[84] PHIPA, s. 36(1)(b)(ii)

[85] PHIPA, s. 36(1)(c)

[86] PHIPA, s. 36(1)(d)

[87] PHIPA, s. 36(1)(g)

[88] PHIPA, s. 36(1)(g), *Supra* note 36 at 306

[89] *Supra* note 36 at 316

[90] PHIPA, s. 37(1)(c)

[91] PHIPA, s. 37(1)(i)

[92] PHIPA, s. 37(1)(d)

[93] PHIPA, s. 37(1)(e)

[94] PHIPA, s. 37(1)(h)

of the Act, including preparation of a research plan; approval of the research by a research ethics board; and written agreement.[95]

Permitted Disclosures without Consent

The Act permits the disclosure of PHI to particular HICs where such disclosure is reasonably necessary for providing health care and consent cannot be obtained in a timely way. This is subject to express instructions from the individual.[96] Other circumstances of permissible disclosure include the following:

- where there are reasonable grounds to believe disclosure is necessary to eliminate or reduce a significant risk or serious bodily harm to a person or group of persons.[97] Reference may also be had to the common law duty to warn, health professional standards that recognize the duty to warn and mandatory reporting requirements under existing legislation

- for a proceeding or contemplated proceeding in which the HIC or agent is a party or witness if it relates to a matter at issue[98]

- pursuant to a warrant, subpoena, summons, court order or similar requirement, in which case, only the information specified ought to be provided. Where a summons or subpoena is received, no PHI ought to be disclosed until authorized by a court or administrative tribunal

- where disclosure is to a researcher for the purpose of research and a HIC has received written application, a research plan that satisfies the Act, a copy of the Research Ethics Board decision, and enters into an agreement with the researcher that satisfies the Act[99]

- where disclosure is to a person who is carrying out an inspection, investigation or procedure authorized by warrant or by law.[100] This provision does not provide independent authority directing HICs to disclose PHI to police or law enforcement authorities without consent. Rather, it reinforces that a HIC may provide PHI to a law enforcement agency in accordance with a warrant or statutory powers of investigation, for example, the disclosure of PHI to a Coroner or a police officer authorized by the Coroner in the exercise of powers under the *Coroners Act*

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[95] PHIPA, s. 37(1)(j)

[96] PHIPA, s. 38(1)(a)

[97] PHIPA, s. 40

[98] PHIPA, s.41

[99] PHIPA, s. 44

[100] PHIPA, s. 43(1)(g)

- where disclosure is to the Chief Medical Officer of Health or a Medical Officer of Health for *Health Protection and Promotion Act* purposes[101]

- where disclosure is to a regulatory college for purposes of enforcement of the *Drug and Pharmacies Regulation Act, Regulated Health Professions Act, 1991* or an Act mentioned in Schedule 1 to the *Regulated Health Professions Act, 1991*[102]

- disclosure of information to the Public Guardian and Trustee, Children's Lawyer or Children's Aid Society so that they can carry out their statutory functions[103]

- a HIC that is a *facility* that provides health care may disclose the fact that an individual is a patient or resident in a facility; the individual's general health status described as critical, poor, fair, stable or satisfactory (or similar terms); and the location of the individual in the facility.[104] Disclosure may only be made if the HIC has given the individual the first reasonable opportunity to object to such a disclosure and the individual has not objected. This section refers to an individual who has been "admitted" to the facility, and as such, its application is somewhat limited.

- For the purpose of contacting a relative, friend or potential substitute decision-maker of the individual, if the individual is injured, incapacitated or ill and unable to give consent personally[105]

- Where the patient is deceased, or is reasonably suspected to be deceased, for the purpose of identifying the individual and for the purpose of informing any person whom it is reasonable to inform in the circumstances of the circumstances[106]

- To the Workplace Safety and Insurance Board where the patient has a claim or open case[107]

Where Disclosure is Permitted in Emergency or Urgent Circumstances

The IPC notes that while PHI is protected by privacy and access laws in Ontario, "it is also important to realize that these protections are not intended to stand in the way of the disclosure of vital – and in some cases, life-saving – information in emergency or other urgent situations."[108] The disclosure of PHI is permissible in "emergency and limited other situations",

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[101] PHIPA, s. 43(1)(h)

[102] PHIPA, s. 43(1)(b)

[103] PHIPA, s. 43(1)(e)

[104] PHIPA, s. 38(3)

[105] PHIPA, s. 38(1)(c)

[106] PHIPA, s. 38(4)

[107] PHIPA, s. 43(1)(h)

[108] IPC, *Fact Sheet: Disclosure of Information Permitted in Emergency or other Urgent Circumstances*, Number 7 July 2005 at 1

where a person's consent has not been obtained if the information comes from, in the case of the health care sector, a HIC or someone acting on behalf of the HIC.

Under PHIPA, a HIC may disclose PHI if the HIC believes on reasonable grounds that the disclosure is necessary to eliminate or reduce a "significant risk of serious bodily harm to a person or group of persons… Such circumstances would even override an individual's prior express instructions not to disclose the relevant personal health information."[109] For example, if a health care practitioner's client was at risk of committing suicide, the health care practitioner could disclose the client's PHI to that client's family or physician if there were reasonable grounds to believe that such disclosure was necessary to reduce the risk of suicide.[110]

The disclosure of harm provision under PHIPA can also be read in conjunction with the common law duty to warn and health professional obligations. For example, the College of Physicians and Surgeons recognizes a duty to inform or a duty to warn. For example, where a physician has reason to believe that a patient will carry out threats of violence against a specific person or group of persons, the physician should report details of the threat to police or in some instances, the intended victim. Reports generally include the threat, the situation, the clinician's opinion and the information upon which the opinion is based.[111]

The Supreme Court of Canada[112] has also provided some useful guidelines in terms of when a duty to warn may be triggered, recognizing that this will involve a professional judgment on the part of the clinician:

1. Identifiable: there is a clear risk to an identifiable person or group of persons

2. Seriousness: there is a risk of serious bodily harm or death; and

3. Imminence: the danger is imminent.

Mandatory Disclosure

The above scenarios sketch out the circumstances when disclosure is permissible. There are also a number of situations where a HIC has a legal obligation to disclose PHI to specified entities. Examples include the reporting of:

- suspected child abuse or neglect under the *Child and Family Services Act* to a Children's Aid Society;
- health conditions that make it dangerous for an individual to drive to the Ministry of Transportation;
- certain deaths to the Coroner;

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[109] *Ibid.* at 2

[110] *Ibid*., See also PHIPA, s. 40(1)

[111] The College of Physicians and Surgeons of Ontario, Mandatory Reporting Policy #3-05, published January/February 2006

[112] *Smith* v. *Jones*, [1999] S.C.J. No. 15 (S.C.C.)

- communicable and reportable diseases to the Medical Officer of Health;
- sexual abuse by a health professional or termination of employment or privileges for reasons of incapacity, incompetence or professional misconduct;
- loss or theft of narcotics or targeted substance under the federal *Controlled Drugs and Substances Act*

In all of these situations, the HIC ought to ensure that it clearly follows the statutory requirements in carrying out the disclosure.

Conclusion:

As with other privacy legislation, consent is clearly central to PHIPA. The Act seeks to achieve an appropriate balance between individual privacy rights and the need to ensure that there is appropriate and necessary communication in the provision of health care, and for those secondary functions ancillary to the provision of health care.