AUTHORIZATION FOR REPRESENTATION

This form **must** be completed if you are filing a complaint on behalf of the patient.

The investigation process generally requires the collection of the patient's personal and confidential health information. The College requires documentation confirming your authority to represent the patient and receive such information on their behalf.

Please choose from one of the sections below (A, B or C) that best describes your authority. Depending on the circumstances, the level of documentation required to support your authority may vary. Enclosing the appropriate documentation will allow the College to process your complaint faster and share important details with you.

If you have questions about how to complete this form, please contact the College's Professional Conduct Coordinator at 709-726-8546 or by email, complaints@cpsnl.ca

A. The patient is a child

◯ I am the child's parent and have legal custody of the child. (No further documentation is required.)

◯ I am the child's legal guardian. **I have attached copies of the relevant legal documents.**

PATIENT'S NAME _____ MCP # _____ DOB _____

COMPLAINANT'S SIGNATURE _____ DATE _____

PATIENT'S SIGNATURE (Age 12+ only) _____ DATE _____

B. The patient has asked me to file on their behalf

◯ The patient is fully capable to file a complaint, but has asked me to file this complaint on their behalf.

To allow you to file the complaint, the patient must provide the following consent:

- I understand that my representative will be considered the complainant for the purposes of processing this complaint.
- I understand that my representative may receive details concerning my personal health information during the investigation of this complaint and that the College will communicate only with my representative unless I state otherwise.
- I understand that I can withdraw or limit this authorization at any time by providing written notice to the College.

AUTHORIZATION FOR REPRESENTATION

(continued)

I agree to _____ making this complaint on my behalf with my permission to view my medical information and any other information that might be relevant to this complaint.

PATIENT'S NAME _____ MCP # _____ DOB _____

PATIENT'S SIGNATURE _____ DATE _____

COMPLAINANT'S SIGNATURE _____ DATE _____

C. The patient is not capable to represent themselves

◯ The patient is unable to represent themselves because they are deceased. I have the legal authority to represent the patient and **I have attached copies of the relevant legal documents** (e.g. letters of probate/administration, last will and testament, etc.).

◯ The patient is unable to represent themselves because they are incapable. I have the legal authority to represent the patient and **I have attached copies of the relevant legal documents** (e.g. power of attorney, letters of guardianship, etc.).

◯ The patient is unable to represent themselves and I do not have the legal authority to represent the patient, but the legal representative has authorized me to act as the representative for the purposes of this complaint.

To allow you to file the complaint, the authorized representative must provide the following consent and attach copies of the relevant legal documents:

I agree to _____ making this complaint on the patient's behalf with my permission to view the patient's medical records and any other information that might be relevant to this complaint. I confirm that I have the legal authority to give this permission.

PATIENT'S NAME _____ MCP # _____ DOB _____

COMPLAINANT'S SIGNATURE _____ DATE _____

PATIENT'S LEGAL REPRESENTATIVE (please print) _____

SIGNATURE OF PATIENT'S LEGAL REPRESENTATIVE _____

RELATIONSHIP TO THE PATIENT _____ DATE _____

(e.g., parent, spouse, child, executor, ...)