

REQUEST TO LOCK PERSONAL HEALTH INFORMATION (LOCK-BOX)

Person complet	ing this form and reques	ting restrictions/lockbox:				
Patient	Substitute Decision I	Maker				
Patient Name:	st Name)	(Given Name)				
			(Middle Name)			
DOR:	B: (YYYY/MM/DD)					
Address:						
Telephone No.: _	none No.: HCN#:					
	his section if you are act I signing authority:	ing on behalf of a patient as	Substitute Decision Maker			
Printed Name:			· · · · · · · · · · · · · · · · · · ·			
Telephone No.: _		SDM's relationship to pation	ent:			
	RESTRICTION TO CO	NSENT/LOCKBOX REQU	JEST DETAILS			
way(s):			nealth information in the following			
Specific range	of visits (enter dates)	to				
All Records						
Person (s)						
Other:						
swered to my sat my personal heal	isfaction. I understand that th information (PHI) will re	my request for restrictions rela	r) have read and understand the stions and had my questions an- ated to the use and disclosure of nind, I am required to contact CMH tions and unlock my PHI.			
Signature of patie	ent or SDM:					
Witness:						
	(YYYY/MM/DD)					

By signing this request form, the following is information is understood and the risks are acknowledged;

- This instruction may prevent hospital staff and medical professional staff from accurately assessing your health status. This may result in duplicate diagnostic procedures or ineffective or insufficient treatment as a result of not having necessary information, which could lead to serious consequences up to and including disability and death.
- The College of Physicians and Surgeons of Ontario believes patient safety should remain paramount.
- When CMH shares your personal health information with another health care provider, it is a legal requirement to inform the provider that some information has been withheld due to restrictions requested by the patient/SDM— Personal Health Information Protection Act 2004 s. 20(3).
- As per s. 71(1) of the Personal Health Information Protection Act 2004, CMH will be immune from any
 actions or proceedings for damages that may result from this restriction on use/disclosure or lockbox of
 your personal health information.
- As is permitted by law, restricted/locked information may be used and/or disclosed in an emergency situation without written consent from the patient/SDM if the disclosure is necessary for the purpose of eliminating or reducing a significant risk of serious bodily harm to a person, including harm to a patient or group of patients.
- It is required by law to provide personal health information to the Ministry of Health under certain circumstances regardless of a patient's request to restrict or lockbox information.
- I acknowledge it is my responsibility to discuss my wishes with my Substitute Decision Maker and other Health Care Providers involved in my health care. I also understand that my request for a lock-box is not retroactive and only applies to future uses and disclosures of my health information.

OFFICE USE ONLY

Verification of identity of individual requesting restriction to consent for use/disclosure of PHI/Lockbox:							
Form of ID:	☐ Driver's License	☐ Passport	☐ Notarized Letter	☐ Lawyer's Letter			
	Other (specify)						
ID Checked	by: (Printed Name)		(Signature)				