CAMBRIDGE MEMORIAL HOSPITAL
700 Coronation Blvd.,
Cambridge, ON N1R 3G2
519-621-2330

REQUEST TO UNLOCK PERSONAL HEALTH INFORMATION (LOCK-BOX)

Person completing this form to remove restriction (lock-box):

❑ Patient ❑ Substitute Decision Maker

Patient Name: _____
(Last Name) (Given Name) (Middle Name)

DOB: _____ (YYYY/MM/DD)

Address: _____

Telephone No.: _____ HCN#: _____

Only complete this section if you are acting on behalf of a patient as Substitute Decision Maker (SDM) with legal signing authority:

Printed Name: _____

Address: _____

Telephone No.: _____ SDM's relationship to patient: _____

CONSENT TO UNLOCK PERSONAL HEALTH INFORMATION

I wish to unlock my personal health information in the following way(s):

❑ Specific visit (enter date) _____
❑ Specific range of visits (enter dates) _____ to _____
❑ All Records
❑ Person (s) _____
Other: _____

I, _____ (print name of requestor) understand that my request to unlock my personal health information (PHI) is effective as of this date and will remain in place.

Signature of patient or SDM: _____

Witness: _____

Date: _____ (YYYY/MM/DD)

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)