Patient "Lock Box" Request Form

Based on the *Personal Health Information Protection Act, 2004*

Health Information Services
1235 Wilson Avenue, Toronto, ON M3M 0B2
(P) 416-242-1000 ext. 82300 (F) 416-242-1085
Email: privacy@hrh.ca

A patient or their substitute decision maker (SDM) has the right to request that Humber River Hospital (HRH) does not share some or all of their health records to physicians, health care providers within HRH, external health care providers such as hospitals or specialists, etc. Although not formally defined in the *Personal Health Information & Protection Act* (*PHIPA*), the term **"lock box"** and its provisions with respect to personal health information is incorporated in the legislation.

PATIENT INFORMATION Medical Record Number:______________________________

Patient Name: ____ Date of Birth: ______________________
LAST NAME *FIRST NAME* *(DD/MM/YYYY)*

Address: ____
STREET ADDRESS *CITY* *PROVINCE* *POSTAL CODE*

Phone Number: __________________________ E-mail: ____

TO BE COMPLETED ONLY IF SUBSTITUTE DECISION MAKER (SDM) IS REQUESTING "LOCK BOX"

SDM Name: ____ Relationship to Patient: __________________
LAST NAME *FIRST NAME*

Address: ____
STREET ADDRESS *CITY* *PROVINCE* *POSTAL CODE*

Phone Number: __________________________ E-mail: ____

LOCKING DETAILS

Please indicate below at which level you would like for your health record to be locked:

☐ Complete health record (everything)

☐ Specific visit: ______________________________
(DD/MM/YYYY)

☐ Specific range of dates: From ____________________ to ____________________
(DD/MM/YYYY) *(DD/MM/YYYY)*

☐ Other (Please provide as much detail as possible):

____

____

Prior to signing this document, the patient or SDM:

- Understands that limiting access to health information may affect the ability of health care providers to provide safe and reliable treatment.
- Understands that the request cannot be applied retroactively (i.e. HRH cannot prevent accesses and/or releases that occurred in the past).
- Understands that the request does not affect uses or disclosures of information that are permitted or required by law without patient consent.
- Is aware that they have the option to withdraw the above instructions at any point in the future.
- Understands that a new request to "lock box" their health records must be completed after every visit.
- Agrees to include a scanned copy of photo ID with this form if unable to have a witness sign this document.

Signature of Patient or SDM: ______________________________ Date: ______________________________
(DD/MM/YYYY)

Signature of Witness: __________________________ Print Name of Witness: __________________________