Holland Bloorview
Kids Rehabilitation Hospital

Client Name:_____

Health Record Number:_____

Date of Birth:_____

AUTHORIZATION – REQUEST to "LOCKBOX" PERSONAL INFORMATION

The purpose of this consent is to document the patient/client's request to "LockBox" personal health information and that the requesting person understands the consequences of such a decision and the conditions in which the information cannot be held back.

Name of the client *(please print)* _____

I request and authorize Holland Bloorview to lock the contents and records associated with:

_____

_____

_____

_____

This information will be held back from any other Holland Bloorview staff, outside agencies or individuals, without my expressed consent and request to do so.

I understand holding back this information from other clinicians may affect my future treatment or care.

I also understand that confidentiality will NOT be maintained under the following conditions:

a. if information has been subpoenaed by the court.

b. under conditions where abuse of any kind by anyone (either past or present) is suspected.

c. when the person being seen for consultation is thought to be at risk of harming themselves or others.

_____ _____

Signature of client or substitute decision maker *Date & time*

_____ _____

Name of substitute decision maker (Please print) *Relationship to the client*

_____ _____

Signature of Witness *Date & time*

_____ _____

Name of Witness (Please print) *Relationship of witness to patient*

* C O N L O C K B X *