Holland Bloorview
Kids Rehabilitation Hospital

Client Name:_____

Health Record Number:_____

Date of Birth:_____

AUTHORIZATION – REQUEST to "UNLOCK-BOX" PERSONAL INFORMATION

The purpose of this consent is to confirm the request to "UnLock-Box" personal health information contained in the health record pertaining to the following client.

Name of the client *(please print)* _____

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

_____

_____

_____

_____

I understand that unlocking the health record and associated personal health information will allow for its use and disclosure as required for the purposes of providing health care, and as mandated by the Personal Health Information Protection Act. I understand that I can in the future exercise my right to reinstate the lock-box by completing an Authorization – Request to Lock-Box Personal Health Information.

_____ _____
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 client*

* C O N U N L O C K B X *