

Client Name: _____

Health Record Number: _____

Date of Birth: _____

AUTHORIZATION – REQUEST to “LOCKBOX” PERSONAL HEALTH INFORMATION

The purpose of this consent is to document the patient/client’s request to “lock” 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.

Complete this form to block, modify or allow access to your personal health information in HB’s custody or control for the purposes of providing health care. Please note that your records may be accessed for purposes, including:

Administrative purposes;
Quality assurance;
Legal proceeding;
As part of an investigation; or
Any other purposes as permitted by the Personal Health Information Protection Act

The consent directive may be withdrawn or modified at the requestor’s discretion.

Submission Instructions: The completed form may be submitted in person, by mail or by fax with copies of your proof of authority documentation/identification (required if you’re submitting the request as a substitute decision-maker) to:

a. In Person/Mail:
Health Information Management Dept.
Holland Bloorview Kids Rehabilitation Hospital
150 Kilgour Road, Room 5W165
Toronto, ON M4G 1R8

b. Fax: 416-425-5709

If the request is **urgent** and the user is comfortable with sharing information via email communication, the consent form can be sent by email to:

releaseofinformation@hollandbloorview.ca

Name of the client (please print) _____

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

- ☐ Lock the entire record
☐ Lock Entire Record but allow access by specific person or by Person Profile (Doctor, Registration, HIM, etc.)
☐ Lock Specific or all historical visits
☐ Lock Specific or all historical visits for everyone except for specific people or by Person Profile (Doctor, Registration, HIM, etc.)

Comment:



Holland Bloorview

Kids Rehabilitation Hospital

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. Any locked personal health information will not be disclosed or accessible on the Connect2Care portal.

If you wish to grant access to specific individuals, please indicate their names below:

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:

- Administrative purposes; Quality assurance; Legal proceeding; As part of an investigation; or Any other purposes as permitted by the Personal Health Information Protection Act
- Under conditions where abuse of any kind by anyone (either past or present) is suspected.
- 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

Identification Verified by HIM Staff

☐ Yes

☐ No



* C O N L O C K B X *