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.

Complete this form to unblock, 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The consent directive may be withdrawn or modified at the requestor's discretion.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 unlock the contents and records associated with:

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

Comment:

Holland Bloorview
Kids Rehabilitation Hospital

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 patient*

Identification Verified by HIM Staff

☐ Yes

☐ No