308 Nipigon, ON P0T 2J0
Phone (807) 887-5252 ext. 2
Fax (807) 887-5991

Patient Lockbox Request and Consent Form

Instruction for Patients

You have the right to ask that we not share some or all of your health record with our staff and/or associated health care providers or ask us not to share your health record with your external health care providers (such as a Nipigon District Family Health Team or specialist). This is informally known as asking for a "lockbox".

Before signing this form, please read our *Patient Lockbox Information Brochure: How to Restrict Access to your Health Record*. If you have any questions, please ask your physician or the Privacy Officer.

PATIENT INFORMATION (please print)

Last Name: _____ First Name: _____ Middle Initials: ___

Date of Birth: _____
(yyyy/mm/dd)

Mailing Address: _____

Telephone #: _____

IF YOU ARE MAKING THE REQUEST AS A SUBSTITUTE DECISION-MAKER (SDM), WE REQUIRE THE FOLLOWING INFORMATION ABOUT YOU: (please print)

Last Name: _____ First Name: _____

Mailing Address: _____

Telephone #: _____

Relationship to Patient: _____

LOCKING DETAILS

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

- ❑ Complete health record (everything)
- ❑ Specific visit: (enter date) _____
- ❑ Specific range of dates: from _____ to _____
- ❑ Other, such as specific employees, etc: (Please provide as much detail as possible)

_____
_____
_____

PATIENT CONSENT

I have read the *Patient Lockbox Information Brochure: How to Restrict Access to your Health Record.* The lockbox has been explained to me. The risks of placing a lockbox on records have been explained to me. I have had the chance to ask questions and my questions have been answered. I consent to the lockbox being put into place for the details outlined above.

_____ _____ _____

(Name of Patient or SDM) (Signature) (Date: yyyy/mm/dd)

INTERVIEW WITH PATIENT/SDM (Internal Use) Date of Request: _____

(yyyy/mm/dd)

OUTCOME: ❑ Complete File Lock ❑ Specific Visit ❑ Specific range of dates ❑ Excluded Employee

Details:

_____
_____
_____

Copy Provided to Patient: ❑ Yes ❑ No

_____ _____ _____

(Name of Privacy Officer) (Signature) (Date)