ATLAS

❑ TOH General ❑ TOH Civic ❑ TOH Riverside
❑ UOHI ❑ Hawkesbury ❑ Renfrew ❑ SFMH
❑ WDMH ❑ KDH ❑ DRDH ❑ GHC
❑ Other specify _____

AFFIX LABEL

MRN:

Last name:

First name:

Date of birth:

# CONSENT DIRECTIVE REQUEST FORM

## Information and Instructions

The Atlas Alliance Epic Health Information System (HIS) is a tool that connects and contains electronic health records from nine (9) hospital organizations in the Champlain LHIN. The Atlas Alliance Members ("Members") include The Ottawa Hospital (TOH), Deep River District Hospital, Group Health Centre, Hawkesbury and District General Hospital, Kemptville District Hospital, St. Francis Memorial Hospital, Renfrew Victoria General Hospital, The University of Ottawa Heart Institute, The Ottawa Hospital Academic Family Health Team, and Winchester District Memorial Hospital.

The Personal Health Information Protection Act provides patients with the option of requesting that personal health information (PHI) be blocked from further use and disclosure, except in certain situations, where it is permitted by law. PHI may be stored in a number of different places, including in paper records, in electronic health record systems, or in other electronic systems shared with organizations outside of the HIS.

Please complete this form if you wish to block access to your PHI in the HIS and submit it in person to the Members Health Records Department, where you received patient care.

Please note that this request cannot be applied retroactively.

**Risks of a Consent Directive:**

There are some risks for you to consider when adding a Consent Directive to your HIS. These risks include:

1. Your health care team may be prevented from accessing your relevant health information, which may result in a delay in your care.

2. Your clinician may not have current or accurate information required to safely provide you with care and in some cases may be unable to offer you treatment.

3. Staff may need to contact you at inconvenient times, to obtain express consent to access your HIS.

4. You may receive multiple calls from different staff in the hospital who are involved in your care.

**You may reduce these risks by considering a request for the Consent Directive to apply only to specific individuals or records rather than to your entire chart.**

## REQUEST FOR IMPLEMENTATION OF A CONSENT DIRECTIVE

### PART A: Patient Information

| Legal First Name: | Middle Initial(s): | Legal Last Name: |
|---|---|---|
| | | |

| Date of Birth (yyyy/mm/dd): | Health Card Number: | Medical Record Number: |
|---|---|---|
| | | |

| Street Address: |
|---|
| |

| City: | Province: | Postal Code: |
|---|---|---|
| | | |

| Telephone Number: | Email: |
|---|---|
| | |

## Substitute Decision Maker (SDM) Information (if applicable)

Legal First Name: | Legal Last Name:

Street Address:

City: | Province: | Postal Code:

Telephone Number: | Email: | Relationship to Patient:

❑ Attached is a copy of documentation that provides authority as SDM

## Preferred Method of Communication

What is the best way to contact you?

❑ Telephone ❑ Email

❑ I acknowledge and understand that email messages are not encrypted, and therefore, the hospital cannot guarantee the security and confidentiality of messages I send or receive.

May we leave a detailed voicemail or email message?

❑ Yes ❑ No

May we send a confirmation to you by email or mail to the address provided on this form?

❑ Yes – Email ❑ Yes – Mail ❑ No

Details: _____

_____

## PART B: Consent Directive Request Details

**Instructions**

I, _____

(Requester or SDM's name – please print)

wish to place the following conditions on any further use or disclosure of my personal health information (PHI).

Request Change (choose one):

❑ New consent directive

❑ Modify existing consent directive

❑ Remove existing consent directive

**If a consent directive is being added, or modified, please confirm the following.**
**I wish to lock:**

❑ My entire health record from all individuals.

❑ Specific appointment/visit/hospital stay (department and date): _____

❑ Specific individuals (names and their designation): _____

_____

## Statement of Understanding

- I have reviewed the above information and understand that there are potential consequences and risks in restricting access to my PHI from my health care providers. I am willing to accept and to take responsibility for these consequences and risks.
- I acknowledge that if the hospital receives a referral request for me that my chart will be reviewed by the hospital so that the referral request may be assessed and processed.
- If I have any questions, or concerns, I will contact my clinician to discuss them.
- I understand that in some situations, the hospital is *permitted or required* by law to use or disclose my PHI, regardless of my consent directive instructions.
- I understand that I can, at any time, contact the hospital's Health Records Department or Privacy Office to revoke or modify this consent directive.
- I will respond to any questions by the Health Records Department, the Privacy Office, and/or my clinical team, to assist them in processing this request.
- I understand that by submitting this form, I am making a consent directive request and that I may hear from Health Records, privacy or clinicians to discuss this request.

## Authorization

| Name of Requester/SDM (print) | Signature | Date (yyyy/mm/dd) |
|---|---|---|
| | | |

| Name of Witness (print) | Signature | Date (yyyy/mm/dd) |
|---|---|---|
| | | |

## PART C: Identification (for Health Records Department use only)

| Identification validated date (yyyy/mm/dd): | Identification validated by:<br>❑ Clinician ❑ Health Records ❑ Other: _____ |
|---|---|

Identification provided:
❑ Driver's license ❑ Passport ❑ Citizenship Card ❑ Other – please specify: _____

| Validated by: Name and role (print) | Signature | Date (yyyy/mm/dd) |
|---|---|---|
| | | |

## Part D: Response to Consent Directive Application (for Privacy Office use only)
## Request Process Details

| Date of initial contact with patient (yyyy/mm/dd): | Date written request received from patient (yyyy/mm/dd): |
|---|---|
| | |

Request Change (choose one):
❑ New consent directive ❑ Modify existing consent directive ❑ Remove existing consent directive

Additional Details:

_____

_____

_____

_____

_____

_____

| Date Consent Directive Applied (yyyy/mm/dd): | Date Notification Letter Sent (yyyy/mm/dd): |
|---|---|
| | |

| Processed by: Name and Role (print) | Signature | Date (yyyy/mm/dd): |
|---|---|---|
| | | |