Electronic Health Record Consent Form – ConnectingGTA

Restrict or reinstate access to information in the provincial electronic health record (EHR)

INSTRUCTIONS TO THE PERSON MAKING THE REQUEST:

- Please complete this form with as much information as possible. Fields indicated with an asterisk (*) are mandatory fields. This will help eHealth Ontario fulfill your request.
- eHealth Ontario only accepts requests from the patient or someone authorized to make the request for the Patient (i.e., substitute decision maker). You will need to:
  - Provide proof of your identity (please see attached instructions for valid forms of identification)
  - If you are not the patient, prove that the patient has allowed you to view his or her information (please see attached instructions for valid forms of identification)
- Mail or fax the completed form to:
  - Mail: eHealth Ontario Privacy Office, P.O. Box 148, 777 Bay Street, Suite 701, Toronto, Ontario, M5G 2C8
  - Fax: (416) 586-4397 or 1 (866) 831-0107
- Please do not use email to submit this form.
- If you have questions about this form, contact the eHealth Ontario Privacy Office at 416-946-4767 or email contact Privacy@ehealthontario.on.ca with your name and phone number.

REQUESTOR'S CONTACT INFORMATION			
(To be completed by person making the request)[1]			
*First name:	Middle initial(s):	*Last name:	
*Mailing address:		*Title:	
*City:		*Province:	*Postal code:
*Preferred phone (daytime):			
Relationship: ☐ Patient ☐ Substitute decision maker			
Preferred method of contact: ☐ Mail ☐ Telephone		Permission to leave voicemail ☐ Yes ☐ No	
PATIENT INFORMATION			
*First name:		*Last name:	
*Gender: ☐ Male ☐ Female		*Date of birth: MM/DD/YYYY	
*Health card number/** Medical record number:			
*Mailing address:		* Preferred phone (daytime):	
*City:		*Province:	*Postal code:

[1] If a HIC is making the request please leave the *Requestor's Contact Information* section blank and complete the *HICs Only* section on page 3.
** Medical record number is only required if the health card number is not available.

Electronic Health Record Consent Form – ConnectingGTA

Restrict or reinstate access to information in the provincial electronic health record (EHR)

TYPE OF REQUEST (check all that apply)

CONSENT DIRECTIVE REQUEST

	*Type of Request	*Description of request
☐	Create a consent directive (Note: By selecting this box, your electronic health record, e.g., assessment information, X-ray report, will not be available to health care providers, and may impact your care.)	
☐	Modify an existing consent directive	
☐	Remove an existing consent directive	

*Consent Directive Details

☐ Global consent directive

☐ Domain consent directive
domain name:

☐ HIC–records consent directive
HIC name:

☐ HIC–agents consent directive
HIC name:

☐ Agent-level consent directive:

First name:	Last name:	Other information (address, contact information):
License number:	College name:	
Organization:	Organization ID:	
Organization:	Organization ID:	
Organization:	Organization ID:	
Organization:	Organization ID:	

Electronic Health Record Consent Form – ConnectingGTA

Restrict or reinstate access to information in the provincial electronic health record (EHR)

IDENTIFICATION

Please include a photocopy of:

- Your identification
- If you are asking for health information about someone else, proof that he or she has allowed you to see the information

Please see the identification requirements at the end of this form for acceptable forms of ID and documentation.

SIGNATURE

Name (print) :	Date: MM/DD/YYYY
Signature:	*Before sending this form to eHealth Ontario, make sure you included:* ☐ *Completed form* ☐ *Photocopy of identification* ☐ *If you are asking for someone else, proof that you have permission from the patient.*

MUST BE COMPLETED BY HEALTH CARE CUSTODIANS (HICS) ONLY

HIC to complete when making the consent directive request on behalf of the patient

*Facility name:	*Site/hospital name:	
*Patient medical record number:	*Requestor's job title:	
*First name:	*Last name:	
*Title:	*Business phone (include ext.):	*Business email:
Special instructions:		

FOR eHEALTH ONTARIO OFFICE USE ONLY

Form completed: ☐ Yes ☐ No	Remedy ticket #:
Identity verfied: ☐ Yes ☐ No	

FOR UHN USE ONLY

Consent directive request form validation

☐ Patient/client found in client registry

☐ Patient/client is created in client registry — If selected, patient's ECID in CR:

☐ Agent is found in provider registry — If selected, agent's UPI in PR:

☐ Agent is created in provider regsitry

☐ HIC is a participating organization		
Consent directive registration ☐ Consent directive is registered	By:	Date: MM/DD/YYYY
☐ Consent directive is verified and tested	By:	Date: MM/DD/YYYY
☐ eHealth Ontario is notified	By:	Date: MM/DD/YYYY
Notes:		

IDENTIFICATION REQUIREMENTS

Identification Requirements
Please include photocopies of the relevant document(s) below to confirm your identity and your authority to view the health information if you are asking for health information that is not yours.

If you have trouble obtaining the documents, you may also ask your health care provider to contact eHealth Ontario to confirm your identity and authority.

1. If you are asking for health information about yourself, you must include a photocopy of one of the documents from list A:

2. If you are asking for health information about another person, you must include a photocopy of one document from list A and one photocopy of a document from list B:

LIST A: Proof of Identity	LIST B: Proof of Authority	
	Patient Is:	One of the following sets of documentations
• Identification from a federal, provincial, municipal or state authority • Student card (if 18 years or younger) • Letter from a health care organization that confirms the requestor's identity (i.e., that the individual is who they say that they are)	11 years or younger	• Birth certificate for the individual • Identification for both parents from a federal, territorial provincial, municipal, or state authority • Signatures from both parents appearing in the birth certificate
		• A legal document demonstrating that the individual has sole custody or guardianship for the patient
		• Letter from a health care organization that confirms the requestor's has the authority to view the health information
	Individual is 12 to 18 years old	• Signed letter from the individual indicating the requestor has the authority to view his or her health information • Student card or identification from a federal, territorial provincial, municipal or state authority for the individual
		• A legal document demonstrating that the Requestor has sole custody or guardianship for the individual
		• Letter from a healthcare organization that confirms the Requestor's has the authority to view the health information
	Individual is 19 years or older	• Signed letter from the individual indicating the requestor has the authority to view his or her health information • Identification from a federal, territorial provincial, municipal or state authority for the individual
		• A legal document demonstrating that the requestor has sole custody or guardianship for the individual
		• Letter from a health care organization that confirms the requestor's has the authority to view the health information

Examples of Documents

Document	*Example*
Identification from a federal, territorial provincial, municipal, or state authority	*Driver's license, passport, citizenship card, certificate of Indian status, Ontario photo card*
Student Card	*Howard Park Public School, St. Vincent Academy, Parkdale Collegiate*
Letter from a health care organization in Ontario	*Letter from Mount Sinai Hospital saying that you are Jane Doe or that you are Jane Doe and have authority to view Janet Yan's health information*