ATLAS

❑ TOH General ❑ TOH Civic ❑ TOH Riverside
❑ UOHI ❑ Hawkesbury ❑ Renfrew ❑ SFMH
❑ 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 six (6) hospital organizations in the Champlain LHIN. The Atlas Alliance Members ("Members") include The Ottawa Hospital (TOH), Hawkesbury and District General Hospital, St. Francis Memorial Hospital, Renfrew Victoria Hospital, The University of Ottawa Heart Institute and the Ottawa Hospital Academic Family Health Team.

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 care.

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
May we leave a detailed voicemail message? ❑ Yes ❑ No

❑ 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 send a confirmation letter to the address provided on this form? ❑ Yes ❑ 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).

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 received 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.
- 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 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 the Health Records, Privacy Office 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: ❑ 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):