Lockbox (Consent Directive) Request Form

- Please complete this form with as much information as possible. Fields marked with an asterisk (*) are mandatory.
- The University Health Network (UHN) only accepts requests from the patient, or someone authorized to make a request for the patient (i.e. substitute decision maker). You will be required to provide proof of your identity.
- Send the completed form and a copy of your proof of identity to the UHN Privacy Office in one of these ways:
  - Mail: University Health Network
    Privacy Office
    190 Elizabeth Street
    R. Fraser Elliott Building, 2nd floor
    Toronto ON M5G 2C4
  - Email: privacy@uhn.ca Please note that email is not a secure method to communicate private information. It can be sent to the wrong recipient, intercepted and/or copied. **If you decide to send us your request and documents via email, you are acknowledging and accepting this risk.**
  - Secure File Transfer: Using https://fileshare.uhn.ca/ encrypts your documentation. Follow the instructions on the website.
- If you have questions, please contact the UHN Privacy Office at 416-340-4800 ext. 6937 or email Privacy@uhn.ca with your name and phone number.

Part I – Patient Information		
*First and Last Name:		*OHIP or Medical Record #:
*Date of Birth:	*Telephone #:	Email address:
*Mailing Address:		
City:	Province:	Postal Code:
* ☐ I have attached a copy of the patient's identification issued by a federal, provincial, municipal or state authority (i.e. driver's licence, health card, passport)		I give permission for UHN Privacy to leave a voicemail message at the number above: ☐ Yes ☐ No
Part II – Substitute Decision Maker Information (if applicable)		
First and Last Name:		Telephone #:
Address:		Email address:
City:	Province:	Postal Code:
☐ I have attached documentation demonstrating that I am the patient's substitute decision maker (e.g. Court order for Guardianship, Power of Attorney for Personal Care)		I give permission for UHN Privacy to leave a voicemail message at the number above: ☐ Yes ☐ No

Part III – Request Details

*Type of request:

☐ Restrict personal health information (i.e. prevent access and/or release)

☐ Modify an existing restriction (i.e. change access and/or release)

☐ Remove an existing restriction (i.e. allow access and or/release)

Personal health information may be stored in a number of different places, including in UHN's electronic systems and paper record storage and in other electronic systems shared with organizations outside of UHN. Your information can be restricted in different ways depending on the system. Each patient request will be evaluated on a case-by-case basis. **Please provide a description of your request below. Be as specific as possible.** Consider whether you wish to lock all of your health information or only specific parts of it, and whether you want it locked for all of UHN or only for certain individuals. **This request will not prevent information about your care at UHN from being sent to your family doctor, referring doctor or Ontario Health for its shared systems; if this is what you want to do, please discuss with us.**

The Privacy Office will contact you within five business days to discuss and clarify your request.

☐ I have attached additional details regarding this request.

Part IV – Understanding & Authorization

- I understand that limiting access to health information may affect the ability of health care providers to provide safe and reliable treatment.
- I understand that my request cannot be applied retroactively (i.e. UHN cannot prevent accesses and/or releases that occurred in the past).
- I understand that my request does not affect uses or disclosures of information that are permitted or required by law without patient consent.
- I am aware that I have the option to withdraw my instructions at any point in the future.

*Signature of Patient/ Substitute Decision Maker:	*Date (dd/mm/yyyy):
*Signature of Witness:	*Date (dd/mm/yyyy):