Release of Information
Health Information Department
Markham Stouffville Hospital
381 Church Street, PO Box 1800
Markham ON, L3P 7P3

REQUEST TO LOCK PERSONAL HEALTH INFORMATION

Information and Instructions for PATIENTS

The Personal Health Information Protection Act (PHIPA) provides patients with the option of requesting that personal health information be locked from use/disclosure at the written request of the patient or substitute decision maker (SDM).
The Privacy Office will review the patient's request to lock records and provide information on the potential implications and risks of locking personal health information.

Patient Name	Date of Birth (DD/MM/YY)	Patient I.D. #
Address:	**Health Card #**	
Phone # (Best Daytime):	Alternate #:	

DESCRIBE THE PERSONAL HEALTH INFORMATION YOU WANT LOCKED (Select One)

- ☐ Specific visit (enter date): ______________________________
- ☐ Specific historical date range: From ______________ to ______________
- ☐ The entire contents of the MSH hospital file of the date of this request

Risks and Implications of Locking your Records of Personal Health Information (PHI)

PATIENT ACKNOWLEDGEMENT

- I understand that, should this be request be approved, a lock on my records may affect the ability of the hospital staff and physicians to accurately assess my healthcare. I understand there is a risk that care may be affected and/or delayed if all personal health information is not available to care providers
- I understand that this direction applies strictly to the official hospital medical record. Physicians providing care may keep seperate records and you must contact them directly to express your wishes for locking your personal health information held in their custody or control.
- I understand that incertain situations, my personal health information may be disclosed in an emergency situation without my express consent as permitted or required by law and if the disclosure is necessary for the purpose of eliminating or reducing a significant risk of serious bodily harm to a person or group of persons.
- I understand that this request does not have any retroactive affect.
- I understand that a record cannot be locked during active care (e.g. inpatient, clinic visit)
- I understand that I will be informed by the hospital whether this request has been approved or denied.

The nature, affects and risks of locking my personal health information have been explained to me and I confirm that I understand the explanation. I have had the opportunity to ask questions and these have been answered to my satisfaction.

______________________________ ______________________________ ______________________________
Patient / Substitute Decision Maker Signature | Relationship of SDM | Date

____
Print Name

INTERVIEW WITH PATIENT / DESIGNATE (Hospital Use Only)

Date of Request: ______________________________ Outcome: ______________________________

______________________________ ______________________________ ______________________________
Staff Signature | Print Name | Date