REQUEST AND CONSENT TO SEAL OR UNLOCK PERSONAL HEALTH INFORMATION REQUEST FORM

Patient Name:	
Health Card Number:	**Date of Birth:**
Address:	**Telephone:**
Patient Signature:	**Date:**
To be Completed if Substitute Decision Maker (SDM) is Requesting Seal	
SDM Signature:	**Date:**
Relationship to Patient:	**Telephone:**

Please list the name(s) of the healthcare provider(s) or clinic(s) where the information you would like sealed was created:

Complete Part A to Seal Records
Complete Part B to Remove Seal

Part A: Personal Health Information You Want Sealed

☐ Specific visit (DD/MM/YYY) _____

☐ Specific Range of dates: from _____ to _____

☐ Complete Health Record up until the date of this request

☐ Person (s) _____

☐ Other (please provide as much detail as possible)

Click here to enter text.

Implications of Implementing a Sealed record:

☐ I understand that by sealing my Personal Health Information (PHI) my Care Providers may not have access to PHI that they need in order to provide the best possible care in a timely manner.

☐ I understand that I may have to undergo duplicate tests, procedures and/or health history questions, as applicable, if information is sealed and unavailable to Providers.

☐ I understand that sealed PHI may only be overridden with my express consent or in the event of serious bodily harm to myself or others.

☐ I understand that the application of a sealed record does not have retroactive effect, nor does it affect the access, use and disclosure of Personal Health Information my healthcare provider where permitted or required by law.

Please complete and submit form to:

Privacy Coordinator at 186 Erie St Suite 100, Collingwood, ON L9Y 4T3

or via email privacy@gbfht.ca or via fax at 705-444-1393

Part B: Removal of Sealed record

☐ I wish to remove the sealed record ("unlock") conditions from my Personal Health Information (PHI).

I wish to remove the following sealed record conditions:

Click here to enter text.

☐I understand that by removing the sealed record conditions from my Personal Health Information (PHI), my provider is able to access, use and disclose this information for the purposes of care as required and regulated by privacy and healthcare laws.

Signature:

Please complete and submit form to:

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