North Huron Family Health Team

Patient Lockbox Request

Instruction for Patients

You have the right to ask that we not share some or all of your health record with Family Health Team staff members or ask us not to share your health record with your external health care providers (such as a hospital or a specialist). This is informally known as asking for a "lockbox".

Before signing this form, please read the *Patient Lockbox Information Brochure: How to Restrict Access to your Health Record*. If you have any questions, please ask your physician or our Privacy Officer who can be contacted at: (519)291-4200

PATIENT INFORMATION (please print)

Last Name: _____ **First Name:** _____ **Initials:** _____

Date of Birth: _____
(yyyy/mm/dd)

Mailing Address: _____

Telephone #: _____ **Alternate #:** _____

IF YOU ARE MAKING THE REQUEST AS A SUBSTITUTE DECISION-MAKER (SDM), WE REQUIRE THE FOLLOWING INFORMATION ABOUT YOU: (please print)

Last Name: _____ **First Name:** _____ **Initials:** _____

Mailing Address: _____

Telephone #: _____ **Alternate #:** _____

Relationship to Patient: _____

LOCKING DETAILS

Please indicate below at which level you would like for your health record to be locked:

- ❑ Complete health record (everything)
- ❑ Specific visit: (enter date) _____
- ❑ Specific range of dates: from _____ to _____
- ❑ Other (Please provide as much detail as possible) _____

_____

_____

_____

PATIENT ACKNOWLEDGMENT

I have read the *Patient Lockbox Information Brochure: How to Restrict Access to your Health Record.* The lockbox has been explained to me. The risks of placing a lockbox on records have been explained to me. I have had the chance to ask questions and my questions have been answered to my satisfaction.

_____	_____	_____
(Name of Patient or SDM)	**(Signature)**	**(Date: yyyy/mm/dd)**
_____	_____	_____
(Name of Witness)	**(Signature)**	**(Date: yyyy/mm/dd)**

INTERVIEW WITH PATIENT/SDM (Internal Use) **Date of Request:** _____ **(yyyy/mm/dd)**

OUTCOME: ❑ **Complete File Lock** ❑ **Specific Visit** ❑ **Specific range of dates** ❑ **Excluded Employee**

Details:

_____

_____

_____

Copy Provided to Patient: ❑ **Yes**

_____	_____	_____
(Name of Privacy Officer)	**(Signature)**	**(Date: yyyy/mm/dd)**