

Algoma Nurse Practitioner-Led Clinic

Section: Privacy	Policy Number: PRIVFORM2018-01
Subject: Privacy and Confidentiality	Effective Date: October 24, 2018
Approved by: Executive Director	
Executive Director _____	Date _____

Patient Request Form to Restrict Collection, Use or Disclosure to Personal Health Information/Lockbox

Person completing this form and requesting restrictions/lockbox:

Patient/Client Substitute Decision Maker

Patient/Client's Name: _____ (First & Last Name)

DOB: _____ (YYYY/MM/DD)

Address: _____

Telephone No.: _____ HC#: _____

Only complete this section if you are acting on behalf of a patient/client i.e., SDM with legal signing authority:

Printed Name: _____

Address: _____

Telephone No.: _____ SDM's relationship to patient/client: _____

RESTRICTION TO CONSENT/LOCKBOX REQUEST DETAILS

I wish to restrict my consent for the use and/or disclosure of my personal health information in the following way(s):

Specific visit (enter date) _____

Specific range of visits (enter dates) _____ to _____

Person (s) _____

Other: _____

I, _____ (print name of requestor) have had the risks associated with placing restrictions on my consent to use/disclose my personal health information (i.e., applying a lockbox) explained to me by a member of my health care team and I have read and understand the risks as outlined on the back of this form. I have had the opportunity to ask questions and have had my questions answered to my satisfaction. I understand that my request for restrictions related to the use and disclosure of my health information (i.e., a lockbox restriction) will remain in place unless I contact the organization's Privacy Officer at 705-942-4717 to rescind my request.

Signature of patient/client or SDM: _____

Date: _____ (YYYY/MM/DD)



