Guelph Family Health Team and Member Clinics

Patient Lockbox Request

Instructions for Patients

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

Before signing this form, please read the Guelph Family Health Tam and Member Clinics' *Patient Lockbox Information Brochure: How to Restrict Access to Your Health Record*. If you have any questions, please ask your physician or Privacy Officer.

Patient Information (please print)

Last Name: _____ First Name: _____ Initials: _____

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

Mailing Address: _____

Telephone #: _____ Alternate #: _____

IF YOU ARE A SUBSITUTE DECISION MAKER (SDM), WE REQUUIRE 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: _____

PATIENT ACKNOWLEDGMENT

I have read the Guelph Family Health Team and Member Clinics' Patient Lockbox Brochure: How to Restrict Access to Your Health Record. The lockbox has been explained to me. The risks of locking my health record 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 ☐ Process Excluded Employee

_____

_____

_____

Copy Provided to Patient: ☐Yes ☐ No

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