REQUEST FORM TO LIMIT ACCESS TO PERSONAL HEALTH INFORMATION

What you should know:

If, in our opinion, sharing your personal health information or the personal health information of the person you legally represent is necessary to enable another health care provider to give you care and treatment, we will assume that you consent.

Also, depending on how our office/clinic is operated, the other health care providers here may be able to see your health information if necessary to give you care and treatment.

If you want to limit how and when other health care providers can see your personal health information inside our office/clinic or outside it, please use this form to tell us. If you need help filing it out we can help you.

Please be aware that depending on how our office/clinic is operated, and how much you want to limit access to the health information, we may not be able to provide you (or the person you represent) with health care services.

Please discuss this matter with your doctor or nurse-practitioner if you want more information.

Whose information do you want to limit access to?

- ☐ My own personal information
- ☐ Another person's personal information

Please complete the "Patient Information" section, and, if acting for someone else, please complete the "Authorized Representative's Contact Information" section, and attach proof that you can legally act on behalf of that individual.

Patient Information

Mr / Mrs / Ms (please circle)

Name			
Address			
City/Town/Province/Postal			
Phone numbers	Main:	Cell:	
Personal Health Number			
Date of Birth (dd/mm/yy)		Email:	

Authorized Representative Contact Information

Mr / Mrs / Ms (please circle)

Name			
Address			
City/Town/Province/Postal			
Phone numbers	Main:	Cell:	
Personal Health Number			
Date of Birth (dd/mm/yy)		Email:	

Please tell us what information you want us to limit access to. Be sure to give the complete patient name that is in the records if it is different from the name given above. If you need more space, please attach a separate sheet of paper.

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Please tell us if you want us to require that a particular person in our office/clinic does not have access to your health record. Please tell us who that person is. You are not required to give us a reason. Someone from our office may discuss this with you further.

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Please tell us if you do not want us to give out some or all of your personal health information to other health care providers outside our office/clinic for the purpose of providing you with health care services. Please be specific about the parts of your personal health information that you do not want us to give out to to other health care providers outside our office/clinic. You are not required to give us a reason. Someone from our office may discuss this with you further.

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Notes of Health Care Provider

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Patient Signature Date (dd/mm/yy)

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Print Name

_____ _____

Authorized Representative Signature Date (dd/mm/yy)

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Print Name

[_] I have attached evidence of my legal authority to act on behalf of the patient named in this form.