Consent Directive Request Form

- Please complete this form with as much information as possible. Fields indicated with an asterisk (*) are mandatory fields. This will help Sinai Health (SH) fulfill your request.
- SH only accepts requests from the patient or someone authorized to make a request for the patient (i.e. substitute decision maker). You will be required to provide proof of your identity.
- Mail, email or fax the completed form to the SH Privacy Office:
  - Mail: 600 University Avenue, Room 1291
Toronto ON M5G 1X5
  - Email: privacyoffice@sinaihealth.ca
  - Fax: 416-586-5280

If you have questions, please contact the SH Privacy & Information Access Office at 416-586-4800 ext. 2101 or email privacyoffice@sinaihealth.ca with your name and phone number.

Part I – Patient Information		
*First and Last Name:		*OHIP or Medical Record #:
*Date of Birth:	*Telephone #:	
*Address:		
*City:	*Province:	*Postal Code:
* ☐ I have attached a copy of the patient's identification issued by a federal, provincial, municipal or state authority (i.e. driver's licence, health card, passport)		I give permission for SH Privacy to leave a voicemail at the number above: ☐ Yes ☐ No
Part II – Substitute Decision Maker Information (if applicable)		
First and Last Name:		Telephone #:
Address:		
City:	Province:	Postal Code:
☐ I have attached documentation demonstrating that I am the patient's substitute decision maker (e.g. Court order for Guardianship, Power of Attorney for Personal Care)		I give permission for SH Privacy to leave a voicemail at the number above: ☐ Yes ☐ No

Part III – Request Details

*Type of request:

☐ Restrict personal health information (i.e. prevent access and/or release)
☐ Modify an existing restriction (i.e. change access and/or release)
☐ Remove an existing restriction (i.e. allow access and or/release)

Personal health information may be stored in a number of different places, including in SH's paper records and electronic systems, or in other electronic systems shared with organizations outside of SH. Your information can be restricted in different ways depending on the system. Each patient request will be evaluated on a case-by-case basis.

Please provide a description of your request below. Be as specific as possible, including the record type(s), name(s) of the clinics and/or health care providers you visited and date range of the record(s).

☐ I have attached additional details regarding this request.

Part IV – Understanding & Authorization

- I understand that limiting access to my personal health information may affect the ability of health care providers to provide safe and reliable treatment.
- I understand that my request cannot be applied retroactively (i.e. SH cannot prevent accesses and/or releases that occurred in the past).
- I understand that my request does not affect uses or disclosures of information that are permitted or required by law without patient consent.
- I am aware that I have the option to withdraw my instructions at any point in the future.

*Signature of Patient/Substitute Decision Maker:	*Date (dd/mm/yyyy):