SOMERSET WEST COMMUNITY HEALTH CENTRE
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TEL: 613-238-1220 FAX: 613-235-2982
Swchc.on.ca

CLIENT LOCKBOX REQUEST FORM

Instruction for Clients
You have the right to ask that we not share some or all of your health record with our staff and/or associated health care providers or ask us not to share your health record with your external health care providers (such as a hospital or specialist). This is informally known as asking for a "lockbox".

Before signing this form, please read our *Client Lockbox Information Brochure: How to Restrict Access to your Health Record*. If you have any questions, please ask your physician or the Privacy Officer

CLIENT INFORMATION (please print)

Last Name: _____ **First Name:** _____ **Middle Initials:**____

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

Mailing Address: _____

Telephone #: _____

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:** _____

Mailing Address: _____

Telephone #: _____

Relationship to Client: _____

N.B: A copy of the document to support your relationship as Power of Attorney for personal care or Legally appointed designate is required.

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) _____

CLIENT ACKNOWLEDGMENT

I have read the *Client 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.

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

INTERVIEW WITH CLIENT/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 Client: ❑ **Yes** ❑ **No**

_____	_____	_____
(Name of Privacy Officer)	**(Signature)**	**(Date**