Ontario Health
Digital Services

Electronic Health Record Consent Directive Request Form

Overview

This form is to be used to make, modify, or withdraw consent to the collection, use and disclosure of an individual's personal health information by means of the electronic health record (EHR) by a health information custodian for the purposes of providing or assisting in the provision of health care to the individual.

Ontario Health only accepts consent directive requests in relation to the Clinical Data Repository (CDR) and the Diagnostic Imaging Common Service (DI-CS). **This form cannot be used for consent directive requests related to the Ontario Laboratories Information System (OLIS) or the Digital Health Drug Repository (DHDR). To make a consent directive request related to OLIS or DHDR please contact the ServiceOntario Infoline at 1-800-291-1405; TTY 1-800-387- 5559.**

Ontario Health only accepts consent directive requests from the individual to whom the personal health information relates or the individual's substitute decision-maker (i.e. a person who is authorized under the *Personal Health Information Protection Act* to consent on behalf of the individual to the collection, use or disclosure of personal health information about the individual). If you are not the individual to whom the personal health information relates, you will need to provide documentation to show that you are entitled to act as the individual's substitute decision-maker. Please visit our website for further information regarding the types of documentation that may be submitted as proof of authority.

Instructions

1. Complete the required (*) fields.
2. Mail or fax the completed form with copies of your proof of authority documentation (required if you're submitting the request as a substitute decision-maker) to:
   a. Mail:

      Privacy Office
      Ontario Health - Digital Services
      777 Bay Street, 7th Floor
      PO Box 148
      Toronto, ON M5G 2C8

   b. Fax: 416-586-4397 or 1-866-831-0107

Please do not use email to submit this form. Consent directive requests submitted via email will be declined and deleted, and the individual will be asked to resubmit the request by mail or fax.

Questions

Questions about this form and how to complete it should be directed to the Privacy Office of the Digital Services business unit of Ontario Health as follows:

- **Phone:** 416-946-4767 or 1-888-411-7742 ext. 64767
- **Email:** OH-DS_privacy@ontariohealth.ca

  Note: Please do not include any personal health information in your email (i.e. health card number or medical history).

- **Mail:**

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Further information is also available on our website:
https://www.ehealthontario.on.ca/en/privacy/managing-access-to-your-ehr

PLEASE COMPLETE THE REQUIRED (*) FIELDS

SECTION 1: INDIVIDUAL'S INFORMATION		
(The individual to whom the personal health information relates)		
*FIRST NAME	*LAST NAME	*DATE OF BIRTH MM/DD/YYYY

*PROVIDE ONE OF THE FOLLOWING:

☐ ONTARIO HEALTH CARD NUMBER:

☐ MEDICAL RECORD NUMBER & NAME OF ORGANIZATION THAT ISSUED THE MEDICAL RECORD NUMBER:

☐ CLIENT HEALTH AND RELATED INFORMATION SYSTEM (CHRIS) CLIENT NUMBER:

*MAILING ADDRESS:

STREET NO.	STREET NAME	UNIT NO.
CITY	PROVINCE	POSTAL CODE

*PLEASE INDICATE YOUR PREFERRED METHOD OF COMMUNICATION:

☐ MAIL ☐ TELEPHONE ☐ EMAIL	PHONE NUMBER (DAYTIME)	PERMISSION TO LEAVE VOICEMAIL ☐ YES ☐ NO

EMAIL ADDRESS

SECTION 2: SUBSTITUTE DECISION MAKER'S INFORMATION (IF APPLICABLE)	
(Only complete this section if you are making this request for another individual)	
*RELATIONSHIP TO INDIVIDUAL:	
*SUBSTITUTE DECISION MAKER'S FIRST NAME:	*SUBSTITUTE DECISION MAKER'S LAST NAME:

*MAILING ADDRESS:

STREET NO.	STREET NAME	UNIT NO.
CITY	PROVINCE	POSTAL CODE

*PLEASE INDICATE YOUR PREFERRED METHOD OF COMMUNICATION:

☐ MAIL ☐ TELEPHONE ☐ EMAIL	PHONE NUMBER (DAYTIME)	PERMISSION TO LEAVE VOICEMAIL ☐ YES ☐ NO

EMAIL ADDRESS

If you are submitting this request as a substitute decision-maker, you must also submit one photocopy of a document that shows you are entitled to act as a substitute decision-maker for the individual identified in Section 1. For example,

a legal document demonstrating you have sole custody or guardianship. Please visit our website for further information regarding the types of documentation that may be submitted as proof of authority.

SECTION 3: CONSENT DIRECTIVE REQUEST DETAILS

3A: TYPE OF CONSENT DIRECTIVE REQUEST (select only one option)

☐ **NEW** CONSENT DIRECTIVE	☐ **MODIFY** EXISTING CONSENT DIRECTIVE	☐ **REMOVE** EXISTING CONSENT DIRECTIVE

3B: CONSENT DIRECTIVE REQUEST DETAILS

<table>
<tr><td rowspan="4">Clinical Data Repository (CDR)

Clinical information from hospitals and home and community care organizations across Ontario, including emergency room reports, consultation reports and discharge summaries, as well as long-term placement details, risk assessments and care plans.

Clinical information from primary care providers (such as a general practitioner or family physician) submitted via certified electronic medical record (EMR) systems, including demographics, medications, allergies and adverse reactions, current health conditions, past medical and surgical history, and immunizations.</td>
<td>☐ Block all users from viewing the individual’s personal health information

☐ Allow all users to view the individual’s personal health information</td></tr>
<tr><td>☐ Block all users from the listed organization(s) from viewing the individual’s personal health information

Name of Organization(s) ________________

☐ Allow all users from the listed organization(s) to view the individual’s personal health information

Name of Organization(s) ________________</td></tr>
<tr><td>☐ Block all users from viewing the individual’s personal health information <u>contributed</u> by the following organization(s)

Name of Organization(s)_________________

☐ Allow all users to view the individual’s personal health information <u>contributed</u> by the following organization(s)

Name of Organization(s)_________________</td></tr>
<tr><td>☐ Block the listed user(s) from viewing the individual’s personal health information

Name of User(s) ________________________

☐ Allow the listed user(s) to view the individual’s personal health information

Name of User(s) ________________________</td></tr>
<tr><td rowspan="2">Diagnostic Imaging Common Service (DI-CS)

Includes diagnostic imaging reports from hospitals and independent health facilities, and relevant</td>
<td>☐ Block all users from viewing the individual’s personal health information

☐ Allow all users to view the individual’s personal health information</td></tr>
<tr><td>☐ Block all users from the listed organization(s) from viewing the individual’s personal health information

Name of Organization(s) ________________</td></tr>
</table>

information to support the retrieval of diagnostic imaging reports from the regional image repositories in Ontario.	☐ Allow all users from the listed organization(s) to view the individual's personal health information Name of Organization(s) ________________
	☐ Block all users from viewing the individual's personal health information <u>contributed</u> by the following organization(s) Name of Organization(s) ________________ ☐ Allow all users to view the individual's personal health information <u>contributed</u> by the following organization(s) Name of Organization(s)_________________
	☐ Block the listed user(s) from viewing the individual's personal health information Name of User(s) ________________________ ☐ Allow the listed user(s) to view the individual's personal health information Name of User(s) ________________________
Ontario Laboratories Information System (OLIS) *Includes lab test requisitions and results from hospitals, community labs and public health labs.*	Ontario Health does not accept consent directive requests in relation to OLIS. To make a consent directive request related to OLIS please contact the ServiceOntario Infoline at 1-800-291-1405; TTY 1-800-387- 5559
Digital Health Drug Repository (DHDR) *Includes drug and prescription information from publicly funded drug programs, publicly funded pharmacy services (e.g. MedsCheck Program, Pharmacy Smoking Cessation Program, or vaccine administration), and monitored drugs programs (narcotics and controlled substances) regardless of the payor.*	Ontario Health does not accept consent directive requests in relation to DHDR. To make a consent directive request related to DHDR please contact the ServiceOntario Infoline at 1-800-291-1405; TTY 1-800-387- 5559

STATEMENT OF UNDERSTANDING

- I understand there are potential consequences and risks implicit in blocking health information custodians from accessing personal health information for the purposes of providing or assisting in the provision of health care to the individual, and I am willing to accept and take responsibility for these consequences and risks.
- I understand that in some situations, Ontario Health may be permitted or required by law to provide personal health information in the EHR to a coroner, medical officer of health, the Ministry of Health, and other persons at the direction of the Minister, regardless of a consent directive.
- I understand that it is an offence under PHIPA to knowingly make an untrue assertion that I am entitled to consent to the collection, use or disclosure of personal information about another individual.
- I understand that by signing and submitting this Consent Directive Request Form to Ontario Health, I am asserting that I am entitled to consent to the collection, use or disclosure of personal health information about the individual identified in Section 1 of this form.

SIGNATURE

I have read and understood the Statement of Understanding above, and I certify that the information given on this form and in any documents submitted as part of this request is correct and complete.

*FIRST AND LAST NAME OF **INDIVIDUAL/SDM** (PRINT):	*DATE: MM/DD/YYYY
*SIGNATURE:	

The personal health information contained on this form is collected by Ontario Health under the authority of Ontario Regulation 329/04, which prescribes Ontario Health as the prescribed organization for the purposes of Part V.1 of PHIPA, and will be used by Ontario Health for the purpose of this consent directive request pursuant to section 55.6 of PHIPA. Questions about this collection or use should be directed to the Privacy Office of the Digital Services business unit of Ontario Health as follows:

- *Phone: 416-946-4767 or 1-888-411-7742 ext. 64767*
- *Email: OH-DS-privacy@ontariohealth.ca*

Note: Please do not include any personal health information in your email (i.e. health card number or medical history).

- *Mail:*

  Privacy Office
  Ontario Health - Digital Services
  777 Bay Street, 7th Floor, PO Box 148
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ADDITIONAL INSTRUCTIONS FOR A SUBSTITUTE DECISION MAKER

What does "Substitute Decision Maker" mean and who is authorized under the *Personal Health Information Protection Act*, *2004* to act as the individual's "Substitute Decision Maker"?

A Substitute Decision Maker is someone who is authorized under the *Personal Health Information Protection Act*, *2004* to consent on behalf of an individual to the collection, use or disclosure of personal health information about the individual.

Substitute Decision Makers can make requests for personal health information on behalf of individuals who do not have capacity to make such requests. You can act as a Substitute Decision Maker for a person who does not have capacity to make their own request if you have capacity **and** you are the highest ranked person on the list below:

- a Substitute Decision Maker within the meaning of the *Health Care Consent Act*, if the collection, use or disclosure of information is connected to the decision of a Substitute Decision Maker about the individual's treatment;
- the guardian of the person or guardian of property;
- the attorney for personal care or attorney for property;
- the representative appointed by the Consent and Capacity Board;
- the spouse or partner;
- a child, a parent, a Children's Aid Society or other person who is allowed by law to give or refuse consent in the place of the parent;
- a parent who has a right of access to the child;
- a sibling;
- a relative; or
- the Public Guardian and Trustee, if no other person meets the requirements.

How does a health information custodian determine whether a person is the Substitute Decision Maker for the deceased individual?

When an individual dies, the estate trustee or the person who has assumed responsibility for the administration of the deceased's estate becomes the Substitute Decision Maker for the deceased individual.

Who can submit a request for a child under 16 years of age?

1. **The child**
2. **A parent of the child** (including a child with capacity), a member of a Children's Aid Society, or another person who is legally able to request personal health information in the place of the parent **with the exception of the situations noted below**:

Ontario Health
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- A child under the age of 16 who consented to their own treatment must decide whether to consent to the collection, use or disclosure of their personal health information related to that treatment.

- If a child under the age of 16 has capacity to make a PCH request and disagrees with the decision of their parent (or the person legally able to make the request in place of the parent), the child's decision overrides the decision of their parent (or the person legally able to make the request in place of the parent).

Note: There are two situations in which the parent (or other legally authorized person) cannot make this request:

- If the personal health information relates to a treatment that a child consented to (or refused to consent); or
- If the child is capable of consenting and makes a decision about their personal health information that conflicts with the parent, or other legally authorized person's decision.

Acceptable identity documents

If the request is related to another individual's health information, you must include **one** photocopy of a document from the list below:

Person is 11 years or younger	Birth certificate for the individual Identification of both parents from a federal, territorial, provincial, municipal, or state authority Signatures from both parents appearing in the birth certificate of the patient.
	A legal document demonstrating that the substitute decision maker has sole custody or guardianship for the patient.
	Letter from a health care organization that confirms the substitute decision maker has the authority to view the health information of the individual.

Person is 12 to 15 years old	Signed letter from the individual indicating the substitute decision maker has the authority to view his or her health information. Student card or identification from a federal, territorial, provincial, municipal or state authority for the individual.
	Letter from a healthcare organization that confirms the substitute decision maker has the authority to view the health information of the individual.

Person is 16 years or older	Signed letter from the individual indicating the substitute decision maker has the authority to view his or her health information Identification from a federal, territorial, provincial, municipal or state authority for the individual.
	A legal document demonstrating that the substitute decision maker has sole custody or guardianship for the individual.
	Letter from a health care organization that confirms the substitute decision maker has the authority to view the health information of the individual.