ST. JOSEPH'S • ST. MICHAEL'S • PROVIDENCE
UNITY HEALTH TORONTO

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 Unity Health Toronto (UHT) fulfill your request.
- UHT 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 or email the completed form to the UHT Privacy Office:
  - Mail: 30 Bond Street
Toronto ON M5B 1W8
  - Email: privacy@unityhealth.to

If you have questions, please contact the UHT Privacy & Information Access Office at 416-864-6088 or email privacy@unityhealth.to with your name and phone number.

Part 1 – Patient Information		
*First and Last Name:		*OHIP or Medical Record #:
*Date of Birth (dd/mm/yyyy)	*Telephone #:	I give permission for UHT Privacy to leave a voicemail at the number above: ◯ Yes ◯ No
*Address:		*City:
*Province:	*Postal Code:	Email:
☐ 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 UHT Privacy to contact me at the email above: ◯ Yes ◯ No
Part II – Substitute Decision Maker Information (if applicable)		
First and Last Name:		Telephone #:
Address:		City:
Province	Postal Code:	Email:
☐ 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 UHT Privacy to contact me at the email 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)

*Site

☐ St. Michael's Hospital ☐ St. Joseph's Health Centre ☐ Providence Health Care

Personal health information may be stored in a number of different places, including in UHT's paper records and electronic systems, or in other electronic systems shared with organizations outside of UHT. 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 healthcare providers to provide safe and reliable treatment.
- I understand that my request cannot be applied retroactively (i.e. UHT 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):