Lockbox Request Form

- Please complete this form with as much information as possible. Fields indicated with an asterisk (*) are mandatory fields. This will help the University Health Network (UHN) fulfill your request.
- The UHN 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.
- M**ail** or fax the completed form to the UHN Privacy & Information Access Office:
  - Mail: University Health Network
    Privacy Office
    190 Elizabeth Street
    R. Fraser Elliott Building, 2nd floor
    Toronto ON M5G 2C4
    416-340-4800 x 6937
  - Fax: 416-340-5304
- If you have questions, please contact the UHN Privacy & Information Access Office at 416-340-4800 ext. 6937 or email Privacy@uhn.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 UHN 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 UHN 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 UHN's paper records, in UHN's electronic systems, or in other electronic systems shared with organizations outside of UHN. 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. If necessary, the Privacy Office will contact you to clarify your request.

☐ I have attached additional details regarding this request.

Part IV – Understanding & Authorization

- I understand that limiting access to 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. UHN 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):
*Signature of Witness:	*Date (dd/mm/yyyy):