camh
mental health is health

D1023A

Client/Patient ID Label

REQUEST FOR IMPLEMENTATION OF A CONSENT DIRECTIVE (LOCKBOX)

PART A: Requester Information

Client/Patient Information

Legal First Name:	Middle Initial(s):	Legal Last Name:
Date of Birth: DD-MM-YYYY	Health Card Number:	Health Record Number:
Street Address: City: Province: Postal Code:		
Telephone Number:	Email:	

Substitute Decision Maker (SDM) (If Applicable)

Legal First Name:	Legal Last Name:
Street Address: City: Province: Postal Code:	
Telephone Number:	Email:
Relationship to client/patient:	

☐ Attached is a copy of documentation that provides authority as SDM

Preferred Method of Communication

What is the best way to contact you?	May we leave a detailed voicemail/message?
☐ Telephone ☐Email ☐I acknowledge and understand that email messages are not encrypted on the hospital email system, and, therefore, CAMH cannot guarantee the security and confidentiality of messages that I send to or receive from CAMH.	☐ Yes ☐ No

May we send a confirmation letter to the address provided on this form?

☐ Yes
☐ No

Details:

Submit completed form to the Information & Privacy Office

PART B: Consent Directive Request Details

Instructions

I, _____ instruct CAMH
Requester's Name (please print)

to limit use and/or disclosure of personal health information about me or about

_____
Client/Patient's Name (please print)

as follows:

_____

_____

_____

☐ Attached is a document or letter with more details regarding my request.

Statement of Understanding

- I have received information from CAMH and understand that there are potential consequences and risks implicit in shielding my personal health information from my health care providers, and am willing to accept and to take responsibility for these consequences and risks. If I have any questions, or concerns, I will contact my clinician to discuss them.
- I understand that in some situations, CAMH may be permitted or required by law to use or disclose my personal health information, regardless of my consent directive instructions.
- I understand that I can, at any time, contact the Information and Privacy Office to revoke this consent directive.
- I will respond to any questions, by the Information and Privacy Office and/or my clinical team, in order to assist them in processing this request.
- I understand that by submitting this form I am making a consent directive request and that I will hear from CAMH to discuss this request further.

Authorization

Signature of Requester/Substitute decision maker: Date:_____/____/____
DD-MM-YYYY

Signature of Witness: _____ Date: _____/____/____
DD-MM-YYYY

Print name of Witness: _____

Submit completed form to the Information & Privacy Office

PART C: Identification (for Information & Privacy Office use only)	
a)	
Identification validated date DD-MM-YYYY	Identification validated by: ☐ Clinician ☐ CAMH Agent, other (complete part b), and sign below)
b)	
Identification provided: ☐ Driver's license ☐ Passport ☐ Citizenship card ☐ Other – please specify:	
_____ Validated by: Name (Please print)	_____ Signature

PART D: Response to Consent Directive Application (for Information & Privacy Office use only) **Request Processing Details**	
Date of initial contact with client: DD-MM-YYYY	Date written request received from client: DD-MM-YYYY
Request Change (choose one): ☐ New consent directive ☐ Modify an existing consent directive ☐ Remove an existing consent directive	
Additional Details:	
Date Consent Directive Applied: DD-MM-YYYY	
Date Notification Letter Sent: DD-MM-YYYY	
Processed by: _____ (Please print name)	

Submit completed form to the Information & Privacy Office