Trillium Health Partners

CONSENT DIRECTIVE REQUEST/REVOCATION FORM

MRN Number:

Patient Information {To be Completed by All Requestors}:

Patient First Name: | **Patient Middle Initial(s):** | **Patient Last Name:**

Patient Date of Birth: | **Patient Health Card Number:**

For Office Use:

☐ Confirmed copy of Patient's and, if applicable, Substitute Decision-Maker's identification issued by a federal, provincial, municipal or state authority is attached.

☐ For deceased Patient, confirmed copy of court-issued Certificate of Appointment as Estate Trustee (with a will or without a will) is attached.

Patient and Substitute Decision-Maker Identity Validated On (date-dd/mm/yyyy):

By: (Print name of THP Staff)

Initials of THP Staff:

Requestor Contact Information {To be Completed by All Requestors}:

Requestor is:
☐ Patient
☐ Substitute Decision-Maker

Mailing Address of Requestor:

Street Number: | Street Name: | Unit Number:

City: | Province: | Postal Code: | Telephone:

Statement by Substitute Decision-Maker {Complete only if Requestor is not the Patient}:

I, the undersigned, hereby declare that I am the person authorized under the Personal Health Information Protection Act, 2004 ("PHIPA") to consent or withdraw consent, on behalf of the Patient named above, to the collection, use and disclosure of the Patient's personal health information and that these instructions take into account the required considerations under PHIPA.

Patient is deceased: ☐ **No** or ☐ **Yes**

(If Yes, provide court-issued Certificate of Appointment of Estate Trustee (either with a will or without a will))

Substitute Decision-Maker Relationship to Patient: | **Date(DD/MM/YYYY):**

Substitute Decision-Maker Name (PRINT): | **Substitute Decision-Maker Signature:**

Statement of Requestor {To be Completed by All Requestors}:

I, the undersigned Patient or Substitute Decision-Maker, understand and agree that:

1. I have been advised to talk to my (or, in the case of a Substitute Decision-Maker, the Patient's) physician or other health care professional(s) about the risks involved in limiting the use and disclosure of personal health information, that such risks include, but are not limited to extra tests, delays in treatment, and death of the Patient, and that Trillium Health Partners is not responsible for any outcome to the extent it is caused or contributed to by the limitations imposed by this Consent Directive
2. This Consent Directive does not prevent access to the Patient's personal health information where technological barriers to such prevention exist
3. This Consent Directive may be revoked at any time in the future upon completion of a revocation form by the Patient or Substitute Decision-Maker.
4. By signing this Consent Directive, I hereby withdraw my consent to the use or disclosure of the Patient's personal health information specified in this Consent Directive for the purpose of providing health care to the Patient. This Consent Directive does not affect those uses or disclosures of Patient's personal health information authorized under PHIPA.
5. This Consent Directive applies only to the information specified herein and that it is not applied retroactively or prospectively. A new Consent Directive is required for future hospital visits.

Requestor Name (PRINT): | **Requestor Signature:** | **Date(DD/MM/YYYY):**

Witness Name (PRINT): | **Witness Signature:**

Trillium Health Partners

CONSENT DIRECTIVE REQUEST/REVOCATION FORM

MRN:

Request Details {To be Completed by All Requestors}:

Type of Request:

- ☐ Implement instructions for the first time
- ☐ Modify existing instructions
- ☐ Revoke instructions
- ☐ Information about Shared Systems*

*Shared Systems include: ConnectingOntario and OLIS**
**Note: OLIS requests can ONLY be initiated by Patient/SDM themselves through Service Ontario NOT by Trillium Health Partners

Description of Request (Please be as specific as possible):

Date (or Date Range) for visits subject to this Consent Directive:

Document Type/Content:

Other:

Requestor Name (PRINT):

Requestor Signature:

Statement of Interpreter:

I, _____ have done my best to accurately translate this form for the individual who has signed above, and will not divulge any information learned during this review except as required by law.

Interpreter Name:

Interpreter Signature:

Date:

FOR OFFICE USE:
Attach Valid Patient or Substitutde Decision Maker Identification and, if applicable, Certificate of Appointment of Estate Trustee