



## EHR Consent Directive Request Form

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### **Overview**

A consent directive gives an individual the option to restrict access to their personal health information in the [Electronic Health Record \(EHR\)](#) by a health information custodian, such as a health care practitioner, for the purposes of providing or assisting in the provision of health care to the individual. This form may be used to request a new consent directive, or modify or withdraw an existing consent directive in the **Clinical Data Repository (CDR) or the Diagnostic Imaging Common Service (DI-CS)**

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.

A consent directive request may be made by the individual to whom the personal health information relates or the individual's substitute decision-maker (SDM) (i.e., a person who is authorized under the *Personal Health Information Protection Act, 2004* (PHIPA) to consent on behalf of the individual to the collection, use or disclosure of personal health information about the individual). A consent directive request made by an SDM must include documentation as proof of authority. For more information, see the *Additional Instructions for a Substitute Decision-Maker* below.

### **Consent Overrides**

*In accordance with PHIPA, there are certain circumstances where a health information custodian may access information in the EHR which is subject to a consent directive. This is known as a consent override. The Electronic Health Record Consent Directive and Consent Override Policy outlines the circumstances where an override is permitted. The policy is available here:*

<https://ehealthontario.on.ca/en/shared/ehr-consent-directive-consent-override-policy>

Note that in some instances, a health information custodian may not have the technical ability to perform a consent override, and therefore may not be able to access the personal health information while a consent directive is in place, even if there is a significant risk of serious bodily harm to the individual to whom the information relates or to another person or group of persons.

### **Instructions to Make, Modify or Withdraw a Consent Directive**

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

a. **Online:** <https://consentform.ontariohealth.ca/>

b. **Mail:**  
Chief Privacy Officer  
Privacy Office, Ontario Health  
777 Bay Street, Suite 701  
PO Box 148

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

**Please do not use email to submit this form. To protect the privacy of individuals and the confidentiality of personal health information, Ontario Health does not accept consent directive requests by email. Consent directive requests submitted by email will be declined and deleted, and the individual will be asked to resubmit the request by mail, fax or online through Ontario Health's website.**

### Questions

Questions about this form and how to complete it should be directed to Ontario Health's Privacy Office as follows:

- **Phone:** 416-946-4767 or 1-888-411-7742 ext. 64767
- **Email:** [OH-DS\\_privacy@ontariohealth.ca](mailto: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:**  
Chief Privacy Officer  
Privacy Office, Ontario Health  
777 Bay Street, Suite 701  
PO Box 148  
Toronto, ON M5G 2C8

- **Fax:** 416-586-4397 or 1-866-831-0107

**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
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\*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.
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CITY	PROVINCE	POSTAL CODE
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\*PLEASE INDICATE YOUR PREFERRED METHOD OF COMMUNICATION:

<input type="checkbox"/> MAIL <input type="checkbox"/> TELEPHONE <input type="checkbox"/> EMAIL	PHONE NUMBER (DAYTIME)	PERMISSION TO LEAVE VOICEMAIL <input type="checkbox"/> YES <input type="checkbox"/> NO
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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.
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CITY	PROVINCE	POSTAL CODE
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\*PLEASE INDICATE YOUR PREFERRED METHOD OF COMMUNICATION:

<input type="checkbox"/> MAIL <input type="checkbox"/> TELEPHONE <input type="checkbox"/> EMAIL	PHONE NUMBER (DAYTIME)	PERMISSION TO LEAVE VOICEMAIL <input type="checkbox"/> YES <input type="checkbox"/> NO
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EMAIL ADDRESS



**Ontario  
Health**

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 see the *Additional Instructions for a Substitute Decision-Maker* attached to this form 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)

<input type="checkbox"/> NEW CONSENT DIRECTIVE	<input type="checkbox"/> MODIFY EXISTING CONSENT DIRECTIVE	<input type="checkbox"/> REMOVE EXISTING CONSENT DIRECTIVE
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#### 3B: CONSENT DIRECTIVE REQUEST DETAILS

<b>Clinical Data Repository (CDR)</b>  <i>Clinical information that comes from hospitals and home and community care organizations across Ontario, which may include emergency room reports, consultation reports and discharge summaries, as well as long-term placement details, risk assessments and care plans.</i>	<input type="checkbox"/> Block all users from viewing the individual's personal health information
	<input type="checkbox"/> Allow all users to view the individual's personal health information
	<input type="checkbox"/> Block all users from the named organization(s) from viewing the individual's personal health information  Name of organization(s) _____

<i>Clinical information that comes 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.</i>	<input type="checkbox"/> Allow all users from the named organization(s) to view the individual's personal health information  Name of organization(s) _____
	<input type="checkbox"/> Block all users from viewing the individual's personal health information contributed by the following organization(s)  Name of contributing organization(s) _____
	<input type="checkbox"/> Allow all users to view the individual's personal health information contributed by the following organization(s)  Name of contributing organization(s) _____

<b>Diagnostic Imaging Common Service (DI-CS)</b>  <i>Includes diagnostic imaging reports that come from hospitals and independent health</i>	<input type="checkbox"/> Block the listed user(s) from viewing the individual's personal health information  Name of user(s) _____
	<input type="checkbox"/> Allow the listed user(s) to view the individual's personal health information  Name of user(s) _____
	<input type="checkbox"/> Block all users from viewing the individual's personal health information  Name of organization(s) _____

<p><i>facilities, and relevant information to support the retrieval of diagnostic imaging reports from the regional image repositories in Ontario.</i></p>	<p><input type="checkbox"/> Allow all users from the listed organization(s) to view the individual's personal health information Name of organization(s) _____</p> <p><input type="checkbox"/> Block all users from viewing the individual's personal health information <u>contributed</u> by the following organization(s) Name of contributing organization(s) _____</p> <p><input type="checkbox"/> Allow all users to view the individual's personal health information <u>contributed</u> by the following organization(s) Name of contributing organization(s) _____</p> <p><input type="checkbox"/> Block the listed user(s) from viewing the individual's personal health information Name of user(s) _____</p> <p><input type="checkbox"/> Allow the listed user(s) to view the individual's personal health information Name of user(s) _____</p>
<p><b>Ontario Laboratories Information System (OLIS)</b></p> <p><i>Includes lab test requisitions and results from hospitals, community labs and public health labs.</i></p>	<p>To make a consent directive request related to OLIS please contact the ServiceOntario Infoline at 1-800-291-1405; TTY 1-800-387- 5559. Ontario Health <u>does not</u> accept consent directive requests in relation to OLIS.</p>
<p><b>Digital Health Drug Repository (DHDR)</b></p> <p><i>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.</i></p>	<p>To make a consent directive request related to DHDR please contact the ServiceOntario Infoline at 1-800-291-1405; TTY 1-800-387- 5559. Ontario Health <u>does not</u> accept consent directive requests in relation to DHDR.</p>

## STATEMENT OF UNDERSTANDING

- I understand there are potential consequences and risks implicit in blocking health information custodians, including hospitals and health care practitioners, 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 some health information custodians, including health care practitioners, may not have the technical ability to perform a consent override, and therefore may not be able to access the personal health information while a consent directive is in place, even if there is a significant risk of serious bodily harm to the individual to whom the information relates or to another person or group of persons.
- I understand that in some situations, Ontario Health may be permitted or required by law to provide personal health information in the electronic health record to other persons, including to a coroner, medical officer of health, the Ministry of Health, and other persons at the direction of the Minister of Health and Long-Term Care, regardless of a consent directive.
- I understand that it is an offence under *Personal Health Information Protection Act, 2004* 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 PERSON SUBMITTING THE REQUEST (PRINT):	*DATE: MM/DD/YYYY
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\*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 a 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 Ontario Health's Privacy Office 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:

Chief Privacy Officer  
Privacy Office, Ontario Health  
777 Bay Street, Suite 701  
PO Box 148  
Toronto, ON M5G 2C8
- Fax: 416-586-4397 or 1-866-831-0107

## **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 a 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:**
  - 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 personal health information, you must include one photocopy of a document from the list below:

<b>Person is 11 years or younger</b>	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.

<b>Person is 12 to 15 years old</b>	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.

<b>Person is 16 years or older</b>	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.