

**Consent Directive Request Form**

- Please complete this form with as much information as possible.. This will help Sinai Health (SH) fulfill your request.
- SH 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.

*First Name:

*Last Name:

*OHIP or Medical Record #

☐ I have attached a copy of the patient's identification issued by a federal, provincial, municipal or state authority (i.e. driver's license, health card, passport)

Preferred Method of Contact ☐ Phone ☐ Email

Address:

City:

Postal Code:

Telephone Number:

Email Address:

Substitute Decision Maker Information (if applicable)

First & Last Name

Email Address

Address:

City:

Postal Code:

Telephone Number:

Preferred Method of Contact

☐ Phone ☐ 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)

Understanding & Authorization

- I understand that limiting access to my personal 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. SH 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.
- If you are requesting a Consent Directive be applied/removed to your health records in the provincial system, ConnectingOntario, then please complete the "EHR Consent Directive Request Form" found at <https://ehealthontario.on.ca/en/privacy/managing-access-to-your-ehr> and submit the form to Ontario Health directly.

☐ I have attached additional details regarding this request on the following page

Signature of Patient/
Substitute Decision Maker:

Date: (dd/mm/yyyy)



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 SH's paper records and electronic systems, or in other electronic systems shared with organizations outside of SH. 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).

If you are using artificial intelligence (AI) in your request, there is a risk it may make it unnecessarily complex or inaccurate. It is your responsibility to ensure your request is genuinely focused on what you are searching for. If not, it may slow down our response or result in a response not focused on your request.

Tips: please keep your request short and straightforward, avoid using legal references or terms, and check for tone to avoid abrupt or inappropriate language.

If you have questions, please contact the SH Privacy & Information Access Office at 416-586-4800 ext.2101 or email privacyoffice@sinaihealth.ca with your name and phone number.