

PLEASE NOTE: Your request cannot be processed until the Centre for Health Information has been able to contact you by telephone to verify your information.

To add or remove a consent directive in HEALTHe NL, please:

- Complete the appropriate fields and sign at the bottom
- Send the signed and completed form to the mailing address

PART 1: ABOUT YOU

Section A: Please complete the following information about yourself or the individual for whom you are adding or removing a consent directive.

LAST NAME	FIRST NAME	MIDDLE INITIAL(S)
<input type="text"/>	<input type="text"/>	<input type="text"/>
MAILING ADDRESS		
APT/UNIT	STREET NUMBER	STREET NAME
<input type="text"/>	<input type="text"/>	<input type="text"/>
CITY/TOWN	PROVINCE	POSTAL CODE
<input type="text"/>	<input type="text"/>	<input type="text"/>
DAYTIME TELEPHONE NUMBER	BIRTHDATE (DD/MM/YYYY)	SEX (CHECK ONE)
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Other <input type="checkbox"/> Female <input type="checkbox"/> Unknown
		MCP NUMBER
		<input type="text"/>

SECTION B: If you **do not** have an MCP Number, please fill in your health card number and issuing jurisdiction below.

HEALTH CARD NUMBER	PROVINCE, TERRITORY OR FEDERAL AUTHORITY
<input type="text"/>	<input type="text"/>

SECTION C: If you are acting on behalf of another individual, complete the following section with your information. If you are adding or removing a consent directive for a minor, all parents or guardians will be asked to provide consent. See page two, Part 4 of this form

LAST NAME	FIRST NAME	DAYTIME TELEPHONE NUMBER
<input type="text"/>	<input type="text"/>	<input type="text"/>

MAILING ADDRESS (IF DIFFERENT FROM ABOVE)

APT/UNIT	STREET NUMBER	STREET NAME OR POST OFFICE BOX	POSTAL CODE
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
CITY/TOWN	PROVINCE	Why can you request this individual's information? (See page two for details)	
<input type="text"/>	<input type="text"/>	<input type="text"/>	

PART 2: ABOUT YOUR REQUEST

SECTION A: Please select the type of request you are making

- Add a consent directive
- Remove a previously requested consent directive

SECTION B: Would you like to be notified when this request is complete?

- Yes, notify me at the mailing address above
- No, I do not need to be notified

PART 3: SECURITY QUESTIONS

Please answer at least THREE of the following questions. You may be asked to answer these questions if you change your directive in the future.

In what city did you meet your spouse? _____	What is the name of the elementary school you attended? _____
Where were you when you heard about 9/11? _____	What is your mother's middle name? _____
In what city/town did you hold your first job? _____	What is your maternal grandmother's maiden name? _____

PART 4: SIGNATURE

Please sign and date this form and return it to the address provided on page two.

<u>X</u> _____	_____	<u>X</u> _____	_____
Your signature	Date signed (DD/MM/YYYY)	Other parent/guardian signature	Date signed (DD/MM/YYYY)

Instructions for Completing the Form

The personal information collected as part of the application process is required to identify you and prove your identity. In the case where you are applying a directive to someone else's profile, the information is also required to identify the patient and confirm that you are authorized to act on their behalf. The personal information is collected under the authority of the *Access to Information and Protection of Privacy Act* and the *Personal Health Information Act*.

Part 1: About you

Section A (about the individual's personal information):

- Fill in this section about the person for whom you would like to add or remove a consent directive (yourself or the person for whom you are acting on behalf).

Section B (if you do not have an MCP Number):

- If you do not have a MCP number, please use the health card number from your province, territory or other jurisdiction.

Section C (acting on behalf of another individual):

- An authorized representative is a person permitted to exercise the rights of an individual. This allows a trusted person to act on an individual's behalf.
- If you are requesting to add or remove a consent directive on someone else's personal health information, please fill in Section C with your own information (fill in Section A with the individual's information).
- Indicate why you can request this individual's information. You must provide documentation to support your authority to do so.

Part 2: About your request

- Please indicate if this request is to add OR remove a consent directive to your EHR profile
- Please indicate if you would like to receive notification when your request has been completed

Part 3: Security Questions

- Answer three security questions
- Should you wish to make a change to your directive in the future, these questions may be used in authenticating that request (making sure you, and only you, are asking to have your consent directive removed).

Part 4: Signature

- Please sign and date the completed form
- By signing the form, I acknowledge that:

I have read and understood the information provided on this form and agree to:

- the consequences of setting HEALTHe NL consent directives;
 - the limitations of HEALTHe NL consent directives;
 - how a HEALTHe NL consent password is used to control access to a HEALTHe NL profile;
 - that HEALTHe NL users are authorized to override HEALTHe NL consent directives based upon professional judgment;
 - my responsibility for the security of the HEALTHe NL consent password;
 - my responsibility to modify or cancel HEALTHe consent directives if I believe they no longer meet my needs;
 - my responsibility to notify the HEALTHe NL Consent Administrator if I have set a consent on behalf of another person and I no longer have authority to act on their behalf;
 - my ability to discuss, modify or cancel HEALTHe NL consent directives and how to do so; and
 - my ability to change HEALTHe NL consent passwords and how to do so.
- If you are placing or removing a consent directive on the EHR of a minor, all parents/guardians will be required to sign and date the form.

How do you submit this form?

By Mail:

NL Centre for Health Information
ATTN: Consent Administrator
70 O'Leary Ave
St. John's, NL A1B 2C7

Please write confidential on your envelope

Due to the sensitive nature of information included with your application, you are encouraged to send it via registered mail.

The Centre for Health Information is not responsible for completed applications and supporting documentation which are lost or intercepted in transit.

For more information or to request forms:

Phone: (709) 752-6000
Email: privacy@nlchi.nl.ca