

ADD OR REMOVE A CONSENT DIRECTIVE IN HEALTHENL

To add or remove a Consent Directive in HealtheNL, please:

- Complete the appropriate fields in the form below and sign at the bottom
- Send the signed and completed form to the address indicated.

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

PART 1: ABOUT YOU

SECTION A: Please enter the following information about yourself or the individual for whom you are adding or removing a Consent Directive.

LAST NAME			FIRS	FIRST NAME			
MAILING ADDRESS							
APT / UNIT STREET NUMBER STREET NAME OR POST OFFICE BOX						POSTAL CODE	
CITY/TOWN			PROVIN	CE SEX (CHECK ONE)			
				FEMALE MALE	OTHER	UNKNOWN	
DAYTIME TELEPHONE NUMBER CELL PHONE NUMBER				BIRTHDATE (DD/MM/YYYY)	Medical Care Plan (MCP)) Number	
SECTION B: If you do	not have a MCP Number	er, please fill in your h	nealth card numb	per and issuing jurisdiction below.			
HEALTH CARD NUMBER			PRO	/INCE, TERRITORY OR FEDERAL AUTHORITY			
SECTION C: If you are	acting on behalf of a	nother individual.	complete the fol	lowing section with your information. If you	u are adding or removing a	a Consent Directive	
for a minor, see page to	-		p	,	· · · · · · · · · · · · · · · · · · ·		
LAST NAME FIRST I			IRST NAME	JAME		DAYTIME TELEPHONE NUMBER	
•	DIFFERENT FROM ABOVE						
APT / UNIT	STREET NUMBER	STREET NAME OR PC	ST OFFICE BOX			POSTAL CODE	
CITY/TOWN			PROVING	CE 1			
				Why can you request this individual's in	formation? (See page two	for details)	
PART 2: ABOUT YOU	R REQUEST						
SECTION A: Please se	lect the type of request	you are making.	1	SECTION B: Would you like to be notified	d when this request has b	een fulfilled?	
□ Add a Consent Directive				\Box Yes, notify me at the mailing address above when the request has been fulfilled			
Remove a previously	requested Consent Dire	ective		\Box No, I do not need to be notified			
PART 3: SECURITY Q Please answer at least		questions. You may b	be asked to answ	ver these questions if you change your direc	tive in the future.		
In what city did you me	et vour spouse?						
In what city did you meet your spouse?				What was the name of your elementary school you attended?			
\A/I				School you attended.			
Where were you when you heard about 9/11?				What is your mother's middle name?	1		
In what city/town did you hold your first				What is your maternal grandmother's maiden			
job?				name?			
PART 4: SIGNATURE Please sign and date th	is form and return it to t	he address provided	on page two.				
×				X			

Your signature

ewfoundland & Labrador

Health Information

DATE SIGNED (DD/MM/YYYY)

Other parent/guardian signature

01/17

Add or Remove a Consent Directive



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

Centre for

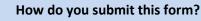
Health Information

- 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:

- o the consequences of setting HEALTHe NL consent directives;
- o 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;
- o 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;
- o my ability to discuss, modify or cancel HEALTHe NL consent directives and how to do so; and
- o 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.

For more information or to request forms: Phone: (709) 752-6000 Email: <u>privacy@nlchi.nl.ca</u>



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.