Labrador-Grenfell Health

Request to Restrict Access and/or
Restrict Disclosure of Personal Health Information

(Please complete Section A; Section B will be completed upon discussion with the designated staff member)

Section A:

Name: _____

Address: _____ **Telephone #:** _____

Date of Birth: _____ **MCP#:** _____

I, _____ (name of client or substitute decision-maker) request that Labrador-Grenfell Health restrict the use and disclosure of the following information contained in:

☐ my health record

☐ the health record

of_____

in the following manner (specify nature of the restriction):

_____
_____
_____

Section B:

I have been informed by _____ (name/title of employee) of the following **(client must initial after each statement):**

1. The potential risks that may exist in restricting the use and disclosure of my health record that may affect the provision of health care to me; such risks may have serious consequences to my health. _____

2. The reasons that Labrador-Grenfell Health requires access to my entire health record to provide the best possible care to me. _____

3. That use and disclosure of this information will be restricted unless it is authorized by law, or to a person involved with my treatment or care in an emergency situation. _____

…/2

4. That restricting the use and disclosure of my health record does not include the recording of personal health information about me where this is required by law or by established standards of professional practice. _____

5. That this request relates to personal health information found in my health record at _____ (name of facility) within Labrador-Grenfell Health. _____

6. This request to restrict the use and disclosure of particular information in my health record is effective as of _____ and cannot apply to previous access to my health record. _____

7. The personal health information that is the subject of my request will be removed from my health record and placed in a file that will be stored separately from the remainder of my record in a secure location within the Health Records Department at _____ . _____

8. The following statement will be placed in bold letters at the front of my health record: ***LIMITED CONSENT DIRECTIVE: THE USE AND DISCLOSURE OF A PORTION OF THIS RECORD HAS BEEN RESTRICTED AT THE EXPRESS REQUEST OF THE CLIENT. REQUESTS FOR ACCESS TO THE COMPLETE RECORD MUST BE MADE TO THE HEALTH RECORDS DEPARTMENT, REGIONAL PRIVACY OFFICER OR DESIGNATE.*** _____

   Please Note: *Where a complete health record has been removed as a result of a limited consent directive, the record will be signed out to a secure file with limited/authorized access only.*

9. The nature and/or limitations of electronic restriction have been explained to me. _____

10. If in future I no longer wish to have the use and disclosure of this information restricted, I must notify in writing to the Health Records Department, Regional Privacy Officer or designate. _____

_____	_____
Signature of Client or Substitute Decision-Maker	Witness
_____	_____
Date	Date

cc: Client's Health Record

LG Health #: P&A-9-0230-1
Developed: November 2011