KINGSTON HEALTH SCIENCES CENTRE

Appendix B
Policy # 09-054

CONSENT DIRECTIVE: REVOKING OF PATIENT CONSENT TO LOCK PERSONAL HEALTH INFORMATION

I, ________________________________, wish to REVOKE my consent to lock my personal
(Print Full Patient Name)

health information.

This REINSTATEMENT of consent does not have a retroactive effect.

Patient Information: (please print)

Date of Birth: ____________________
(yyyy mm dd)

Mailing Address: ____

Telephone #: ____________________ Alternate #: ____________________

Signature: ____________________ Date: ____________________
(yyyy mm dd)

If you are a Substitute Decision-Maker (SDM), we require the following information:

Last Name: ______________ First Name: ______________ Middle Initial(s) ______

Mailing Address: ____

Telephone #: ______________ Alternate #: ____________________

Signature: ______________ Date: ____________________
(yyyy mm dd)

INTERNAL USE **DATE LOCK REMOVED:** ______________
(yyyy mm dd)

Lock Removed From: **Entire Record** ☐ **Sequestered Visit(s)** ☐ **Process Excluded Employee** ☐

COMMENTS: ____

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Staff Signature: ______________ **Staff Printed Name:** ______________ **Date:** ______________
yyyy/mm/dd