KINGSTON HEALTH SCIENCES CENTRE

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

I, _____, wish to REVOKE my consent to lock my personal
(Print Patient Name)
health information.

This REINSTATEMENT OF consent does not have a retroactive effect.

Patient Information: (please print)

D.O.B.: _____
(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: _____ Initials: _____

Mailing Address: _____

Telephone #: _____ Signature: _____

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

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

COMMENTS: _____

_____

_____

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