



Student Wellness Services

Côté Sharp Student Wellness Centre
Mitchell Hall, 69 Union St.
Queen's University,
Kingston, Ontario,
Canada, K7L 3N6
613-533-2506

Lockbox Request Form

You have the right to ask that we not share some or all of your health record with individuals within the Student Wellness Services (SWS), and/or with others outside of SWS. Asking for this restricted access is commonly referred to as asking for a 'lockbox' to be placed on your health record.

We want you to be fully informed regarding the locking options, and the possible risks associated with a lockbox to be considered in making this decision. After you have submitted this form, you will be contacted by the Executive Director, SWS, or delegate, to discuss your questions or concerns, and the best options to meet your needs that are available within the electronic health record, and any stored paper records.

Student Information

First Name: _____ Last name: _____

Date of Birth (dd/mm/yyyy): _____ Student Number: _____

Address: _____

Phone: _____ Queen's email: _____

I am making this request as a legal substitute decision maker.

Locking Details

Please indicate at what level you would like for your health record to be restricted or locked:

- Lock complete health record (everything).
- Lock clinical note for a specific visit(s) (date): _____
- Lock clinic notes written by specific providers
- Restrict specific individuals from accessing your complete health record
- Restrict the disclosure of your health record to specific health care providers outside of SWS

Please describe your requests above, in as much detail as possible:

(please turn over and complete p2)

Understanding and Authorization

- I understand that limiting access to health information may affect the ability of health care providers to provide safe and reliable care
- I understand that limiting access to health information may affect a health care provider’s decision to provide health care
- I understand that this request does not affect uses or disclosure of information that are permitted or required by law without consent
- I understand that information can be restricted or locked in different ways depending on the features of the electronic health record system
- I understand that I can withdraw these instructions at any time
- I understand that prior to my request being authorized, I will be contacted by the Executive Director, Student Wellness Services (or delegate), to clarify the details of my request, to discuss locking options, and to review the risks and possible outcomes of my request.

Signature: _____ Date: _____

Witness: _____ Date: _____

Discussion with Executive Director, or Delegate, and Individual Requesting Lockbox

Date: _____ In person Telephone

Clarification of Details:

Review of risks

Review of locking options

Decision: _____

Name: _____ Role: _____ Date: _____