

**Form and Letter Templates**

*Version 1.0*

**Disclaimer**

The information in these resources does not constitute legal advice. It is general information intended to assist physicians in understanding their obligations and general duties under the Newfoundland and Labrador *Personal Health Information Act*. *The information is provided as guidance for clinics in Newfoundland and Labrador for developing their privacy program. In the case of a discrepancy between PHIA and the document, PHIA shall be taken as correct.*

The eDOCSNL Privacy and Security Resource materials have been developed to align with applicable legislation and best practices. The eDOCSNL Privacy and Security Resources are based on original work completed by the Saskatchewan Medical Association, EMR Program.

**Table of Contents**

[Access to Personal Health Information Form 4](#_Toc459815253)

[Request for Correction Form 6](#_Toc459815254)

[Consent Directive and Masking Form 8](#_Toc459815255)

[Breach Notification Letter 10](#_Toc459815256)

[Privacy and Security Breach Reporting Form 11](#_Toc459815257)

[Letter of Refusal or Partial Refusal of Access or Referring an Access Request 14](#_Toc459815258)

[Letter of Extension 15](#_Toc459815259)

[Letter Confirming Correction 16](#_Toc459815260)

[Letter Notifying of Notation 17](#_Toc459815261)

[Letter Regarding Correction or Notification to Other Custodians 18](#_Toc459815262)

[Record of Information Holdings 19](#_Toc459815263)

[Record of Destruction of Paper Records 20](#_Toc459815264)

[Personal Health Information Consent for Disclosure 21](#_Toc459815265)

[Patient Email Communications Consent Form 22](#_Toc459815266)

[Patient Email Communications FAQ 23](#_Toc459815267)

# Access to Personal Health Information Form

*This form can be used when patients or their authorized representative want access to the patient’s record. A Healthcare Professional may utilize this form to administer requests for personal health information however, requests may also be made verbally or in another written format.*

*Healthcare Professionals should consider the ability of the patient to pay when charging a fee.  There is no requirement to charge a fee however, if the patient is requesting personal health information that is difficult to compile, the NLMA*[[1]](#footnote-1)*, CMA*[[2]](#footnote-2) *and the Information and Privacy Commissioner[[3]](#footnote-3) provide guidance. A maximum fee of $25.00 for requests of up to 50 pages is appropriate. This fee would include various tasks associated with searching for and providing access to the requested information. After the first 50 pages, the Commissioner recommended a photocopy fee of no more than $0.25 per page.*

The information on this form will be used to respond to your request for your own personal health information or the personal health information of someone whom you are legally entitled to represent.

**Name of Patient**Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other names the information may be under, e.g. maiden name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This information will be used in confirming the correct record

MCP Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth (dd/mm/yy): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Healthcare Professional \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Contact Information**

Street address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City /town: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Prov.\_\_\_\_\_\_ Postal code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tel: (home) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (mobile) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**This request is being made by an Authorized Representative/Third Party**

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City /town: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Prov.\_\_\_\_\_\_ Postal code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tel: (home) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (bus) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The person requesting the personal health information is authorized under the *Personal Health Information Act* or has authority to access this information under \_\_\_\_\_\_\_\_\_\_\_\_\_ (name of legislative or court authority). Attach signed consent or other legal authorization for the applicant to be a designate.

**Details of Request**

1. Please describe, in as much detail as possible, the information you are requesting.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Select all that apply:

* access to information about the disclosure of your information,
* access to review a record or a part of a record,
* a copy of a record or part of a record,
* an audit report of who has accessed your personal health information in it.

1. Select all that apply:

* Receive a photocopy of the record.
  + Please enclose an initial payment of $\_\_\_\_\_\_\_\_\_\_ with your request. You will be provided with an estimate of any additional costs.
* Receive the copies by bonded courier at your expense or you will pick up the records in person.
* View the original record, without receiving a copy.
  + The estimated fee you will be charged $\_\_\_\_\_\_\_\_ for a review of the record by your Healthcare Professional and / or another person
* Someone will review your chart with you. *Place a check in the box if you would like your Healthcare Professional or a designated staff person present as you review the record*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
                   Signature of Patient or Authorized Person                                     Date

**Office Use**

* Identity by driver’s license, passport, or other government issued photo ID confirmed.
* Access request received on (*Date*) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Notice of Extension Sent, include the *Personal Health Information Act* reference that authorizes the extension:
* Notice of Refusal Sent, include the *Personal Health Information Act* reference that authorizes the refusal:
* Refused in its entirety
* Refused in part
* Access request completed

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Healthcare Professional Date

# Request for Correction Form

*This form may be used when a patient or authorized representative wants a correction to a medical record. These requests must be made in writing. A Healthcare Professional may utilize this form to administer requests for corrections to personal health information however, requests may also be made verbally or in another written format. The clinic policy should reflect the manner in which a correction will be accepted.*

The information on this form will be used to respond to your request for correction to your personal health information or the personal health information of someone whom you are legally entitled to represent.

**Name of Patient**Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other names the information may be under, e.g. maiden name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This information will be used in confirming the correct record

MCP Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth (dd/mm/yy): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Healthcare Professional \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Contact Information**

Street address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City /town: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Prov.\_\_\_\_\_\_ Postal code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tel: (home) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (mobile) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**This request is being made by an Authorized Representative/Third Party**

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City /town: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Prov.\_\_\_\_\_\_ Postal code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tel: (home) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (bus) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The person requesting the correction of personal health information is authorized under the *Personal Health Information Act* or has authority to make the request under \_\_\_\_\_\_\_\_\_\_\_\_\_ (name of legislative or court authority). Attach signed consent or other legal authorization for the applicant to be a designate.

**Details of Request**

Please describe, in as much detail as possible, the information you are requesting be amended. Please be aware that if the clinic agrees to make a correction following your request that correction will not remove the original information from the record, however when the record is read the correction will be clearly visible. If your requested correction is not made in the record, your record will contain a notation that you requested the correction but that the requested correction was not made.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Signature of Patient or Authorized Person                                     Date

**OFFICE USE**

Confirmation of identity by driver’s license, passport, other government issued photo ID, or known at clinic.

**DATES**

* Correction request received:
  + Notice of Correction Sent to Patient:
  + Notice of Notation in the Record Sent to Patient
  + Notice to Other Custodians Sent
* Correction request completed
* Request Denied
* Information not created by clinic
* Information is accurate and complete
* Information is not part of patient record
* Applicant cannot legally act on behalf of individual

Name of Healthcare Professional\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Consent Directive and Masking Form

*This form can be used when a patient or authorized representative wishes to limit access to their personal health information and in particular when requesting masking*

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, wish to limit/revoke my consent to any further use or disclosure by [name of clinic or Healthcare Professional] of my personal health information in the EMR. The specific information this directive applies to is: (description of information).

I wish to place the following conditions on any further use or disclosure of my personal health information: (Please specify condition(s))

* Mask my entire electronic medical record
* Mask a specific entry in my electronic medical record (provide details)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Limit access to my electronic medical record to (identify individuals who you want to have access to your records)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that this limitation/revocation of consent does not have a retroactive effect and is only applied to the electronic medical record at [Name of Clinic]. It will not affect the uses and disclosures of my personal health information collected by [name of clinic or Healthcare Professional] where the uses and disclosures are permitted or required by law without consent.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ has explained to me the possible consequences to my timely care because of this consent directive. I also understand that when personal health information is masked the mask can be removed when necessary, for my care or required by law, without my consent.

Signature of Patient or Authorized Representative\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Healthcare Professional Signature Date

**Removal of Consent Directive**

I hereby remove my consent directive. I do this voluntarily and without coercion.

Signature of Patient or Authorized Representative\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Healthcare Professional Signature Date

**Patient Information**

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other names the information may be under, e.g. maiden name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This information will be used in confirming the correct record

MCP Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth (dd/mm/yy): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Healthcare Professional \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Contact Information**

Street address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City /town: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Prov.\_\_\_\_\_\_ Postal code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tel: (home) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (mobile) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**This request is being made by an Authorized Representative/Third Party**

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City /town: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Prov.\_\_\_\_\_\_ Postal code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tel: (home) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (bus) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The person requesting the personal health information is authorized under the *Personal Health Information Act* or has authority to access this information under \_\_\_\_\_\_\_\_\_\_\_\_\_ (name of legislative or court authority). Attach signed consent or other legal authorization for the applicant to be a designate.

**OFFICE USE**

Confirmation of identify by driver’s license, passport, other government issued photo ID, or known at clinic.

# Breach Notification Letter

*This sample letter can be used to notify a patient of a breach of their privacy. It needs to be adapted to address the specific factors of the breach.*

***Forest Medical Associates***

***456 Winter Trail***

***Gambo, Newfoundland and Labrador***

Dear

We are writing to inform you of an incident involving your personal health information on [Date of Breach]. We are notifying you in as timely a manner as possible so you can take swift personal action along with the steps taken by Forest Medical Associates to reduce or eliminate potential harm to you.

The incident involved [brief explanation of what happened]. The personal health information that may have inadvertently been disclosed was: [identify the specific PHI disclosed].

As a result of this incident, we have taken the following corrective actions to prevent a similar incident from occurring: [explain immediate and long term action].

We regret that this breach of your personal health information occurred and wish to express our sincerest apology for any inconvenience or concern that this incident may cause you.

You may wish to take your own steps to minimize any possible harm to you by taking precautions that include

* [list possible steps the patient may take]

You may also contact the Office of the Information and Privacy Commissioner at

Newfoundland and Labrador Information and Privacy Commissioner  
Sir Brian Dunfield Building  
3rd Floor, 2 Canada Drive  
P.O. Box 13004, Station "A"  
St. John’s, NL A1B 3V8

Telephone:  (709) 729-6309  
Toll Free Telephone (within Newfoundland and Labrador): 1-877-729-6039

We, at [Forest Medical Clinic] take very seriously our role of safeguarding your personal health information and using it in an appropriate manner for your health care. We will keep you informed if any additional information regarding the incident becomes available. In the meantime please do not hesitate to contact me at \_\_\_\_\_\_\_\_, or the Office Manager at \_\_\_\_\_\_ for further information on this incident.

# Privacy and Security Breach Reporting Form

*This form should be used when investigating a privacy or security breach. Attach additional sheets if necessary.*

Do not include any information that will lead to the identification of the individual(s) whose information has been breached.

**Background Information**

|  |  |
| --- | --- |
| **Name of custodian** |  |
| **Contact information**  (contact name, telephone number, facsimile, email and mailing address) |  |

**Details of Incident**

|  |  |
| --- | --- |
| **Date breach occurred** |  |
| **Date breach discovered** |  |
| **Location of breach** |  |
| **Description of incident** |  |
| **Estimated number of individuals affected** |  |
| **Description of action taken to contain breach** |  |
| **Was the affected party(s) notified of the incident?**  **If so, what was the date of notification?** |  |
| **Was the affected party(s) notified of his/her right to complain to the OIPC?** |  |
| **Who else has been notified?** | * Patient(s) (Do not provide name(s)) * Other Custodian(s) (Provide name(s)) * NLCHI (Provide name of contact) * Office of the Information and Privacy Commissioner * Newfoundland and Labrador Medical Association * College of Healthcare Professionals and Surgeons – Newfoundland and Labrador * Police (provide contact name) * Insurers * Legal counsel * Vendor * Research Ethics Board * Other: |
| **Is this a breach of personal health information** | Yes/No  Explain: |
| **Describe the information that was breached** *(Check all that apply but do not provide specifics)* | □ Name  □ MCP  □ Other ID/chart number  □ Credit Card Number  □ Full Address  □ Postal Code  □ Medical History  □ Test Orders or Results  □ Images  □ Prescriptions  □ Referral Letter  □ Consultation Report  □ Other information (describe) |
| **Describe the type of harm that may occur to the custodian, another custodian, NLCHI, Government of Newfoundland and Labrador or the profession** | * Breach of contractual obligations * Similar breach likely to reoccur in another EMR or in the EHR * Failure to meet professional standards |
| **Are they any other potential risks** | * Public health and safety * Other |
| **Describe the administrative (training, restricted access), technical (encryption, passwords, etc.) and physical (locks, alarm, systems, etc.) security measures that are directly related to the breach and were in place at the time of the breach.** |  |
| **Describe any long-term strategies that will be taken to improve practices at the clinic.** |  |

# Letter of Refusal or Partial Refusal of Access or Referring an Access Request

*Custodians are required to send the patient a letter when access to his/her own information has been denied. This letter is a sample of one that may be used. PHIA provides for very limited authority for denying access. Select the reason(s) you have denied access from the relevant sections of PHIA listed in the body of the letter below.*

**SAMPLE LETTER**

Dear [Patient Name]

Your request for access to your personal health information made on [date] to [name of Healthcare Professional or clinic] has been refused, in full or in part, in accordance with *the Personal Health Information Act,* Paragraph 58(1), specifically [select one or more of the following reasons for refusing access to the information].

*(a)  another Act, an Act of Canada or a court order prohibits disclosure to the individual of the record or the information contained in the record in the circumstances;*

*(b)  granting access would reveal personal health information about an individual who has not consented to disclosure; or*

*(c)  the information was created or compiled for the purpose of*

*(i)  a committee referred to in subsection 8.1(2) of the Evidence Act,*

*(ii)  review by a standards or quality assurance committee established to study or evaluate health care practice, or*

*(iii)  a body with statutory responsibility for the discipline of health care professionals or for the quality or standards of professional services provided by health care professionals.*

We have enclosed the parts of your record that have not been refused.

The information that cannot be provided to you has been deleted and the rest of the record is now available for you to pick up from [name of person at clinic].

If you have any questions you may speak to [name of Healthcare Professional or privacy officer]. If you disagree with [name of custodian’s] decision not to provide this information to you, you may contact the Office of the Information and Privacy Commissioner of Newfoundland and Labrador at (709) 729-6309 or 1-877-729-6309.

# Letter of Extension

*Healthcare Professionals are required to respond to a patient’s request for access to their personal health information within 60 calendar days. Healthcare Professionals are allowed one extension of an additional 30 calendar days for a limited number of reasons. When preparing the letter, Healthcare Professional must include the section of PHIA that allows for the extension.*

**SAMPLE LETTER**

Dear

On [date], [name of clinic or Healthcare Professional] received your request for access to your personal health information [include dates or other relevant information about the actual personal health information requested].

Please be advised that the 60 day time limit for responding to your request has been extended for an additional 30 days and we expect to respond to your request by [date].

The reason for this extension of time is authorized under *The Personal Health Information Act*, Paragraph 55(2). [Select the section of PHIA that applies.]

*55(2) (a)  meeting the time limit set out in subsection (1) would unreasonably interfere with the operations of the custodian; or*

*(b)  the information consists of numerous records or locating the information that is the subject of the request cannot be completed within the time limit set out in subsection (1).*

We will contact you as soon as your record is available.

If you have any further questions, please feel free to contact [name of Healthcare Professional or privacy officer] at [telephone number].

# Letter Confirming Correction

*Healthcare Professionals are required to send a letter to a patient to confirm that the correction requested has been made.*

***SAMPLE LETTER***

Dear [Patient Name]

On [date] you requested that a correction be made to your medical record. Specifically the request was to [state the request].

This correction has been made to the record.

In addition, the following other custodians have been made aware of the above noted correction:

[List all custodians who have been made aware of the correction if applicable]

If you have any further questions please contact [name of Healthcare Professional or privacy officer] at [telephone and/or email]

# Letter Notifying of Notation

*Healthcare Professionals are required to send a letter to a patient when a requested correction has not been made but a notation has been made in the record.*

***SAMPLE LETTER***

Dear [Patient name]

On [date] you requested that a correction be made to your medical record. Specifically the request was to [state the request].

[Name of Healthcare Professional] has

determined that the information is accurate and complete

Or

determined the information is his professional opinion or a diagnosis.

The correction has not been made to your record but a note has been added to your record with the information you provided to [name of clinic].

If you disagree and believe that a change should have been made, we will attempt to resolve the matter with you. You may also contact the Office of the Newfoundland and Labrador Information and Privacy Commissioner at (709) 729-6309 or 1-877-729-6309.

If you have any further questions please contact [name of Healthcare Professional or privacy officer] at [name of medical practice and telephone number].

# Letter Regarding Correction or Notification to Other Custodians

*When a Healthcare Professional makes a correction or a notation to a record following a patient’s request, the Healthcare Professional is required to notify other custodians or person to whom the Healthcare Professional disclosed the amended or notated information to in the previous year.*

***SAMPLE LETTER***

Dear [Patient Name]

As required under *The Personal Health Information Act* paragraph 63(1) (c) this is notice that [name of clinic] has received a request from [name of patient] to amend their personal health information. We have made the requested correction [describe the information to be amended].

This information was disclosed to you on [date] for [state purpose]. Please make a similar correction in your records.

Or

The requested correction was not made but the following notation was placed in the record. [Describe notation] Please make a similar notation in your records in accordance with *The Personal Health Information Act* paragraph 40(5).

Should you have any questions please contact [name of Healthcare Professional or privacy officer] at [telephone number].

# Record of Information Holdings

*If Healthcare Professionals have several holdings of personal health information it is recommended that this be documented along with the location of the holdings and who has access to each holding. This is an example of record of information holdings.*

**Example Table ONLY. Please update with clinic information.**

|  |  |  |
| --- | --- | --- |
| **Information Holding** | **Location** | **Access** |
| EMR database | Vendor – Rimouski Quebec | Locally – all Healthcare Professionals have full access  Students have time limited restricted access  Employees have restricted access  Contracted IT support upon request |
| EMR Database backup | Vendor – Kelowna BC | IT support |
| Paper Records | Local | All Healthcare Professionals  All staff |
| Paper Records | Local Storage company – sealed boxes | Storage company employees upon request from the  Office Manager |
| Clinical Trial Records | Local server | Participating Healthcare Professional  Research nurse |

# Record of Destruction of Paper Records

*Healthcare Professionals should maintain a record of the records that are to be destroyed. This record should be retained in the clinic files and may also be provided to the company destroying the records. This is a sample of what could be used.*

The records described below are eligible for destruction in accordance with the retention and destructions policies of the [Name of Medical Practice]. At the time of destruction all records were stored at [location of storage]

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Healthcare Professional** | **Patient** | **Type of Information** | **Years of Information** | **Last Year of Access** | **Date of Destruction** |
| Dr. Evergreen | Primrose  Small | Paper Record of patient care | 1952-1980 | 1980 | May 2, 1990 |

The records will be destroyed by [insert name of person or company] by [insert method] on or before [date].

I certify that the records listed above, to the best of my knowledge, are not subject to any current or pending audit, litigation, subpoena, or other legal demand for their retention or disclosure. Further, I attest that the records were retained for [retention period] after the last entry in the record, based on professional requirements and best practices.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Healthcare Professional Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Witness

# Personal Health Information Consent for Disclosure

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, consent to the disclosure of my personal health information to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

The purpose of this disclosure is to assist in the arranging, assessing the need for, providing, continuing, or supporting the provision of, a service requested or required by myself.

Further to this, I understand that this consent is voluntary and can be revoked at any time.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Healthcare Professional

**Withdrawal of Consent Directive**

I hereby withdraw my consent directive. I do this voluntarily and without coercion.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Healthcare Professional

# Patient Email Communications Consent Form[[4]](#footnote-4)

This template is intended as a basis for an informed discussion. If used, physicians should adapt it to meet the particular circumstances in which electronic communications are expected to be used with a patient. Consideration of jurisdictional legislation and regulation is strongly encouraged. Physicians must ensure reasonable safeguards are in place prior to using email to communicate with patients.

**PHYSICIAN INFORMATION:**

|  |
| --- |
| Name: click here |
| Address: |
| Email (if applicable): |
| Phone (as required for Service(s)): |
| Website (if applicable): |

The Physician has offered to communicate using the following means of electronic communication (“the Services”):

|  |  |
| --- | --- |
| (Yes/No) Email | (Yes/No) Videoconferencing (including Skype®, FaceTime®) |
| (Yes/No) Text messaging (including instant messaging) | (Yes/No) Website/Portal |
| (Yes/No) Social media (specify): | |
| (Yes/No) Other (specify): | |

**PATIENT ACKNOWLEDGMENT AND AGREEMENT:**

I acknowledge that I have read and fully understand the risks, limitations, conditions of use, and instructions for use of the selected electronic communication Services more fully described in the Appendix to this consent form. I understand and accept the risks outlined in the Appendix to this consent form, associated with the use of the Services in communications with the Physician and the Physician’s staff. I consent to the conditions and will follow the instructions outlined in the Appendix, as well as any other conditions that the Physician may impose on communications with patients using the Services.

I acknowledge and understand that despite recommendations that encryption software be used as a security mechanism for electronic communications, it is possible that communications with the Physician or the Physician’s staff using the Services may not be encrypted. Despite this, I agree to communicate with the Physician or the Physician’s staff using these Services with a full understanding of the risk.

I acknowledge that either I or the Physician may, at any time, withdraw the option of communicating electronically through the Services upon providing written notice. Any questions I had have been answered.

|  |  |
| --- | --- |
| Patient name: | |
| Patient address: | |
| Patient home phone: | |
| Patient mobile phone: | |
| Patient email (if applicable): | |
| Other account information required to communicate via the Services (if applicable): | |
| Patient signature: | Date: |
| Witness signature: | Date: |

# Patient Email Communications FAQ

*The following questions and answers are guidelines for using email as a method of communication within your clinic. For more information see* ***CMPA Risks of using electronic communication[[5]](#footnote-5)***

***What are the risks associated with my Healthcare Professional using email to communicate with me?***

* + Email transmission is not guaranteed to be secure or confidential; unauthorized individuals may be able to intercept, read and possibly modify e-mail you send or are sent by your Healthcare Professional or clinic.
  + Email may inadvertently be sent to wrong destinations or to the wrong individual.
  + Employers may monitor email sent or received by employer-owned systems.
  + Email can be used to spread viruses, some of which may cause unauthorized email distribution.
  + Email can be forwarded without the authorization or detection of the source author.
  + Shared family email accounts can jeopardize confidentiality.

***When will my Healthcare Professional use email to communicate to me?***

* Email will only be used for non-urgent issues such as routine enquiries or appointment information.
* Email will never be used for communication of serious, urgent or time-critical medical issues like suffering from chest pain or severe low blood sugar levels.
* Email will not be used to discuss sensitive information such as sexually transmitted diseases, mental health problems, drug treatment or alcohol-related disorders.

***What should emails to and from my Healthcare Professional look like?***

* “CONFIDENTIAL” and the reason for the communication should be in the subject line. Ie.“Subject: CONFIDENTIAL – Medical Question”
* State your message simply and include the following:
  + - your full name
    - telephone number (where we can reach you)

***How soon will I hear back from my Healthcare Professional?***

Your Healthcare Professional and/or staff will do their best to respond to email communications in a timely manner. If you don’t hear back within a few days, please phone your Healthcare Professional.

***How will the information in my emails be used?***

The information within your email may be shared with other health care providers as part of your care team or staff at the clinic on a need to know basis. Your Healthcare Professional and their staff will not, however, share emails with third parties not involved with your care without your prior written consent, except as authorized or required by *The Personal Health Information Act (PHIA)*. Please keep in mind that all emails, sent or received, may become part of your health record.

***What should I do if I change my email address?***

You must notify your Healthcare Professional as soon as possible to maintain confidentiality.

***Also…***

Instead of creating a new email, be sure to click **REPLY** when responding to your health care providers email. This establishes an email trail that allows you and your health care provider to track messages, as well as eliminates the need for entering the return email address, therefore reducing chances of entering an address incorrectly. For your own records, you may want to save copies of messages sent and received within your email program.

1. <http://www.nlma.nl.ca/documents/guides/guide_2.pdf> [↑](#footnote-ref-1)
2. <https://www.cma.ca/Assets/assets-library/document/en/advocacy/CMA_records_confidential_PD00-06-e.pdf#search=patient%20fees> [↑](#footnote-ref-2)
3. AH-2012-001; <http://www.oipc.nl.ca/pdfs/ReportPH-2012-001-2012PHIA.pdf> [↑](#footnote-ref-3)
4. https://www.cmpa-acpm.ca/web/guest/-/technology-unleashed-the-evolution-of-online-communication [↑](#footnote-ref-4)
5. https://www.cmpa-acpm.ca/web/guest/-/technology-unleashed-the-evolution-of-online-communication [↑](#footnote-ref-5)