HDH Medical Records Contact (chart pull only), ext. 4115
KGH Information Analysis & Distribution Contact, ext. 3245

Request ID # __________

KGH/HDH DATA REQUEST FORM

According to the Personal Health Information Protection Act (PHIPA): section 44, O.Reg. 329/04, a custodian may permit disclosure of medical records for:

i. teaching purposes, or
ii. scientific research that meets the following policies:
   - KGH 1-120 Research Administrative
   - KGH 9-133 Access to Charts for Student Critical Inquiry Electives
   - KGH 11-150 Health Research
   - KGH/11-160/HDH 6020 Departmental Assistants – Appointment to Medical Services
   - KGH 11-161/HDH 2100 Departmental Assistants – Appointment to Nursing Services (Patient Services)

Date requested: ____________________
YYYY / MM / DD

Request originated from: ☐ KGH ☐ HDH ☐ Other ____________________ (specify)

Reviewer/Contact Information:

Name ____________________ Telephone ____________________
Title ____________________ Pager ____________________
(i.e. Senior Exec., Manager, Physician, Student) Fax ____________________
On Behalf of ____________________ Email ____________________
Dept/Serv/Pgm ____________________

Date requested for: ____________________
YYYY / MM / DD

Use:

Medical	☐ Quality Assurance	☐ Research
Administration	☐ Quality Assurance	☐ Research
Patient Care/Program	☐ Quality Assurance	☐ Research
Education	☐ Critical Inquiry	

____
(Supervisor's signature required for Critical Inquiry)

Intended Use:
☐ Internal
☐ External

Purpose/Study Name:

____

____

Information Requested:

____

Chart Pulls Required ☐ Yes ☐ No Folder: ☐ KGH ☐ HDH

Info/Charts Requested for ____________________
YYYY / MM / DD

Total Charts for Review __________ Number of Charts Per Each Review __________

Is this a multi-doctor or multi-service request? ☐ Yes ☐ No

Authorized By: ☐ Physician ☐ Department Head ☐ Patient Care Mgr ☐ Patient Care Director ☐ Chief Nursing Officer ☐ Chief of Staff ☐ Other ____________________

Ethics Approval: ☐ Yes ☐ No ____________________

Service/Department Head: ____________________
(Please Print Name)

Signature/Status: ____________________ Date: ____________________

I acknowledge that I have received, and understand the note of "Special Instructions" provided to me.

Signature of Recipient ____________________ **Date**: ____________________

SPECIAL INSTRUCTIONS (to be given to recipient):

Aggregate data will not identify an individual patient.

Patient level data must be treated as confidential and be managed as listed below.

USE

The recipient shall use the information only for the purposes as described on the data request form. In all cases when reporting from this material, aggregate or anonymise the data to avoid disclosure of patient identity. (Groups/cells with less than 5 should be reported as <5.)

STORAGE

Personal health information received electronically will be password protected when received from Information Analysis and Distribution. Do not store your password with the CD. It is encouraged to work with this information on a PC on the hospital system within the secure network. Storage of electronic information should be on the network drive to ensure data is backed up and protected against loss. If paper documentation is part of your received information from this request, it should be stored in a locked, secure area.

IF this requested electronic information is being transported from the hospital site, it should be in a password protected file with at least 5 alphanumeric characters, and patient identifying information removed. When removing the personal health information from the hospital, you assume full responsibilities as a custodian of the information.

DESTRUCTION

When your study/request has been completed, all electronic original and backup files should be deleted. Paper documentation containing personal health information must be destroyed by shredding.

INTERNAL USE ONLY

Data Source:

- ☐ Inpatient
- ☐ Day Surgery
- ☐ Regional
- ☐ Clinic
- ☐ Emergency
- ☐ Operating Room
- ☐ ICU
- ☐ Waitlist
- ☐ Decision 1
- ☐ Bed Occupancy
- ☐ Provincial

Service Site: (institution the service occurred)

- ☐ KGH
- ☐ HDH
- ☐ SMOL
- ☐ Other ______________________________

____

Time Period:

Requested: Fiscal/Calendar/Other (Circle) ______________ to ______________

Frequency:

- ☐ AdHoc
- ☐ Yearly
- ☐ Monthly
- ☐ Quarterly
- ☐ Other ______________________________________ (specify)

Delivered On: _________________________
YYYY / MM / DD

Revised On: _________________________
YYYY / MM / DD

Method of Delivery: Email/CD/Floppy/Other ___________________________
(Please Circle)

Delivered To: ____

Password: _______________________

Project Date: _______________________
YYYY / MM / DD

Report Generated By: ____

File Name: ____

File Location: ____