

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 _____ <small>(i.e. Senior Exec., Manager, Physician, Student)</small>	Pager _____
	Fax _____
On Behalf of _____	Email _____
Dept/Serv/Pgm _____	

Date requested for: _____
YYYY / MM / DD

Use:

Medical	<input type="checkbox"/> Quality Assurance	<input type="checkbox"/> Research
Administration	<input type="checkbox"/> Quality Assurance	<input type="checkbox"/> Research
Patient Care/Program	<input type="checkbox"/> Quality Assurance	<input type="checkbox"/> Research
Education	<input type="checkbox"/> Critical Inquiry	

Intended Use:

Internal

External

(Supervisor's signature required for Critical Inquiry)

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:

- | | |
|---|--|
| <input type="checkbox"/> Inpatient | <input type="checkbox"/> ICU |
| <input type="checkbox"/> Day Surgery | <input type="checkbox"/> Waitlist |
| <input type="checkbox"/> Regional | <input type="checkbox"/> Decision 1 |
| <input type="checkbox"/> Clinic | <input type="checkbox"/> Bed Occupancy |
| <input type="checkbox"/> Emergency | <input type="checkbox"/> Provincial |
| <input type="checkbox"/> Operating Room | |

Service Site: (institution the service occurred)

- | | |
|--------------------------------|-------|
| <input type="checkbox"/> KGH | |
| <input type="checkbox"/> HDH | |
| <input type="checkbox"/> SMOL | |
| <input type="checkbox"/> Other | _____ |
| | _____ |

Time Period:

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

Frequency:

- | | | |
|---------------------------------|------------------------------------|--------------------------------------|
| <input type="checkbox"/> AdHoc | <input type="checkbox"/> Monthly | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Yearly | <input type="checkbox"/> Quarterly | (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: _____