Request ID # _____

KHSC 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:
- KHSC 09-055 Personal Health Information Protection
- KHSC 11-021 Research Hospital Appointment
- KHSC 11-150 Health Research
- KHSC 11-160 Departmental Assistant Appointments

Date requested: _____
                           YYYY / MM / DD

Request originated from: KGH Site HDH Site ☐ 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:

			Intended Use:
Medical	☐ Quality Assurance	☐ Research	☐ Internal
Administration	☐ Quality Assurance	☐ Research	☐ External
Patient Care/Program	☐ Quality Assurance	☐ Research	
Education	☐ Critical Inquiry		

                                      _____
                  (Supervisor's signature required for Critical Inquiry)

Purpose/Study Name:

_____

_____

Information Requested:

_____

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

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.

Data Source:

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

Service Site: (institution the service occurred)

☐ KGH
☐ HDH
☐ SMOL
☐ Other _____
         _____

Time Period:

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

Frequency:

☐ AdHoc   ☐ Monthly   ☐ Other _____
☐ Yearly   ☐ 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: _____