eHealth Saskatchewan

eHealth Privacy Service

Request to Mask for PIP and eHR Viewer

I, the undersigned, request that my profile(s) in the Pharmaceutical Information Program (PIP) and/or the eHR Viewer be masked. I accept all risk associated with masking of profiles including, but not limited to, any delay which may be experienced in receiving treatment or any decisions which may be made by healthcare professionals when they do not have access to my PIP and/or eHR Viewer profile(s).

I understand that as part of provincial legislation, a pharmacist must temporarily access my masked PIP profile to fill my medication prescriptions

I understand that I may not have a record in the PIP or eHR Viewer applications at this time but masking will apply to any future records.

I request that my profile be masked in:

- ☐ Pharmaceutical Information Program (PIP)*
- ☐ eHR Viewer

Medication and allergy information from PIP is also in the eHR Viewer. If you wish PIP information to be masked in all applications, please request that the eHR Viewer also be masked.

Once a profile(s) is masked, it (they) will remain masked until a formal request is made to remove the mask. Removing the mask involves submitting a Request to Remove the Mask Form which is available on the eHealth website or by contacting the eHealth Privacy Service.

Personal health information on this form is collected under the authority of *The Health Information Protection Act* (HIPA). This information will only be used to ensure accuracy, and to apply masking to your profile(s). Specifically, the Health Services Number will be used to confirm identity, and authenticate this request in order to protect confidentiality. Personal health information is protected from unauthorized use and disclosure in accordance with HIPA, and may only be collected, used and disclosed as provided in HIPA.

Please fill out the section below:

______________________________ ______________________________
Printed Name of Applicant | Health Services Number of Applicant

______________________________ ______________________________
Date of Birth of Applicant *(yyyy-Mon-dd)* | Phone Number *(During business hours)*

______________________________ _______________ _______________
Address of Applicant | Province | Postal Code

Specify how you would like us to correspond with you:

☐ Mail: Address (*if different from above*):

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☐ Email:* ______________________________

** E-mail transmissions cannot be guaranteed to be secure or error free as emails can be intercepted, corrupted, destroyed, arrive late or incomplete, or contain viruses*

______________________________ ______________________________
Signature of Applicant | Date Signed by Applicant *(yyyy-Mon-dd)*

If you are signing as an Agent for the Applicant, please include evidence of your authority to act as Agent.

Printed Name of Agent	Phone Number *(During business hours)*
Signature of Agent	Date Signed by Agent *(yyyy-Mon-dd)*

Please submit both pages of this completed form to:

Mail: eHealth Privacy Service

Suite 101 - 1901 Scarth Street

Regina, SK

S4P 4L4

Email: privacyandaccess@eHealthSask.ca

Please note that original copies and legible fax copies or document scans will be accepted.

More information about privacy and eHealth programs can be found at: www.eHealthSask.ca