



## eHealth Privacy Service

### Request to Remove the Mask from PIP and eHR Viewer

I, the undersigned, having previously masked my personal health information in the Pharmaceutical Information Program (PIP) and/or the eHR Viewer, request that eHealth Privacy Service remove the mask(s) on my profile(s) in the application(s) I have selected below.

I request that the mask on my profile be removed in the:

- Pharmaceutical Information Program (PIP) and or  
 eHR Viewer,

making all of my information, images and/or reports currently contained in this/these application(s) accessible by authorized users.

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 remove masking from your specified patient 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:		
<input type="checkbox"/> Mail:	Address (if different from above):	
	_____	
<input type="checkbox"/> 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 ( <i>During business hours</i> )
_____ Signature of Agent	_____ Date Signed by Agent ( <i>yyyy-Mon-dd</i> )

***Please submit both pages of this completed form to:***

Mail: eHealth Privacy Service

Suite 101 - 1901 Scarth Street

Regina, SK

S4P 2H1

Email: [privacyandaccess@eHealthSask.ca](mailto: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](http://www.eHealthSask.ca)