

**Request to Mask for PIP, PACS and eHR Viewer**

I, the undersigned, request that my profile(s) in the Pharmaceutical Information Program (PIP), the Picture Archiving and Communication System (PACS) 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 health professionals when they do not have access to my PIP, PACS and/or eHR Viewer profile(s).

I understand that I may not have a record in the PIP, PACS 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)\*
- Picture Archiving and Communication System (PACS)
- 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 profile(s) 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:

<hr/> Printed Name of Applicant	<hr/> Health Services Number of Applicant
<hr/> Date of Birth of Applicant (yyyy-Mon-dd)	<hr/> Phone Number (During business hours)
<hr/> Address of Applicant	<hr/> Province
<hr/> Specify how you would like us to correspond with you:	
<input type="checkbox"/> Mail:	Address (if different from above):
<input type="checkbox"/> Fax:	<hr/>
<input type="checkbox"/> Email:*	<hr/>
<small>* 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</small>	
<hr/> Signature of Applicant	<hr/> 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  
2130 11<sup>th</sup> Avenue  
Regina, SK  
S4P 0J5

Fax: 306-798-0897

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)