Request to Access Personal Health Information

under the ***Personal Health Information Protection Act, 2004***

Name of Health Information Custodian to Whom the Request is being made:

_____

Your Information: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss

Surname _____ Given Name _____ Initials ____

Address _____ Unit _____

City _____ Province _____ Postal Code _____

Telephone _____ Evening _____

Substitute Decision-Maker Information:*

Surname _____ Given Name _____ Initials ____

Address _____ Unit _____

City _____ Province _____ Postal Code _____

Telephone _____ Evening _____

* Please provide documentation to satisfy the health information custodian that you are an authorized substitute decision-maker, if available.

Please provide a detailed description of the personal health information you are requesting and details that will assist in locating this information (e.g. dates, name of health care provider, etc.).

_____

_____

_____

_____

Preferred method of access to records: ☐ Examine Original ☐ Receive a Copy

Signature: _____ Date: _____

For Health Information Custodian Use Only		
Date Received:	Request Number:	Comments:

The personal health information contained on this form is collected pursuant to the *Personal Health Information Protection Act, 2004* ("the *Act*") and will be used for the purpose of responding to your request for access pursuant to section 54 of the *Act*. Questions about this collection should be directed to the privacy Contact Person at the health information custodian where the request for access is made.