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.