



# REQUEST FOR ACCESS TO PERSONAL HEALTH INFORMATION

## **Information and Instructions**

We will provide you with access to your personal health record unless a legal exception applies. We will respond to your request in a timely manner. A fee may be charged, eg. \$30 (includes 20 pages + 25 cents per page thereafter). Please complete Parts A and B of this form and forward to Health Information Services.

### **PART A: PATIENT INFORMATION**

\_\_\_\_\_  
Last Name                      First Name                      Middle Name

\_\_\_\_\_  
Other Name(s)                      Date of birth                      Health Card #

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone Number

### **PART B: ACCESS REQUEST**

1. Specify Visit Date(s) \_\_\_\_\_

2. Information Requested:
- Emergency Record     Discharge Summary     Operative Report     Pathology Report
- X-ray Report             CT/MRI Report             Laboratory Report     ECG
- X-ray Image             CT/MRI Image
- Other – specify \_\_\_\_\_

3. The information requested is for:
- Personal Use
- Ongoing Care – Name of Physician/Healthcare Provider \_\_\_\_\_
- Other purposes – specify \_\_\_\_\_

4. If applicable, date information is required - \_\_\_\_\_

\_\_\_\_\_  
Name of Requestor (Please Print)                      Signature

\_\_\_\_\_  
Relationship if other than Patient                      Phone # (if different than patient)

\_\_\_\_\_  
Date

OFFICE USE ONLY: Proof of Identity  Driver's Licence  Health Card  Other- \_\_\_\_\_

Obtained by \_\_\_\_\_ on \_\_\_\_\_