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.

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 __ Immunization Record

__ 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 _____