



## Freedom of Information & Protection of Privacy Act (FIPPA) REQUEST FOR ACCESS TO RECORDS

Name (last,first,middle) \_\_\_\_\_  
Ms Mrs. Miss Mr Other

Company / Organization (if applicable ) \_\_\_\_\_

Mailing address \_\_\_\_\_

City or Town \_\_\_\_\_ Territory/province/country \_\_\_\_\_

Postal code \_\_\_\_\_

Telephone (day) \_\_\_\_\_ (alternate) \_\_\_\_\_ Fax \_\_\_\_\_

Information requested - Please list dates, events, agencies involved, file numbers, and any other details which will help locate the records. If you are requesting another person's information, you must attach either that person's signed consent for disclosure or proof of authority to act on that person's behalf. If you need more space, please attach a separate sheet of paper.

Preferred method(s) of access to records      Examine original      Receive copy

Your signature X \_\_\_\_\_ Date signed \_\_\_\_\_

**For NDMH Office Use Only**  
Request no. \_\_\_\_\_ Date received \_\_\_\_\_ Privacy Officer \_\_\_\_\_

Please send completed form to:      Nipigon District Memorial Hospital  
Privacy Officer  
Box 37  
Nipigon, ON P0T 2J0

Personal information contained on this form is collected under the Personal Health Information Protection Act (PHIPA) and Freedom of Information and Protection of Privacy Act (FIPPA) and will be used only for the purposes of responding to your request.