



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:

Surname: _____ Given Name: _____

Address: _____ City: _____

Province: _____ Postal Code: _____

Date of Birth: _____ Telephone #: _____

*Substitute Decision-Maker Information**

Surname: _____ Given Name: _____

Address: _____ City: _____

Province: _____ Postal Code: _____

Date of Birth: _____ Telephone #: _____

**Please provide documentation to satisfy the health information custodian that you are an authorized 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 (ie: dates, name of health care provider, etc.)

Signature: _____ Date: _____

Witness: _____ Date: _____

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.