

# Request to Access Personal Health Information under the Personal Health Information Protection Act (PHIPA), 2004

## Mailing Address:

Access and Privacy Unit  
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For Health Information Custodian Use Only

Date Received:

Request Number:

Comments:

Name of Health Information Custodian to whom request is being made:

## Patient information

First name:

Last name:

Address:

City:

Province:

Postal code:

Telephone:

Alternate phone number:

Email address:

## Substitute Decision Maker

Note: A substitute decision maker is a person authorized under PHIPA to consent, on behalf of an individual, to disclose personal health information about the individual.

Verification of identity of individual consenting (or Substitute Decision Maker) to access or disclose information is required.

First name:

Last name:

Address:

City:

Province:

Postal code:

Telephone:

Alternate phone number:

Email address:

## Description of information requested

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.).

Signature of Patient or substitute decision maker:

Date (mm/dd/yyyy):

This Consent for Access to Disclosure will be valid for a six month period as of the date of the signature unless otherwise specified. This authorization may be withdrawn at any time by written notification to the Health Information Custodian, but is not retroactive to information released before consent is withdrawn.

The personal health information contained on this form is collected pursuant to the *Personal Health Information Protection Act, 2044* ("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 personal at the health information custodian where the request for access is made.