

Where the request is being made

Submit your request to the address or fax number above. *Note: Legislation permits a 30-day response time.*

Patient whose information is being requested

Last Name:	Health Card Number:
First Name:	Date of Birth (DD/MM/YYYY):

Information about the person making the request

Last Name:	<input type="checkbox"/> Patient <input type="checkbox"/> Substitute Decision Maker Relationship to patient: <input type="checkbox"/> Other (specify):
First name:	
Contact #:	
Mailing Address:	

Records being requested

<input type="checkbox"/> All health records on file <input type="checkbox"/> All health records for a specific time frame From: <table style="display: inline-table; border-collapse: collapse;"><tr><td style="border-right: 1px solid black; width: 20px; text-align: center;"> </td><td style="border-right: 1px solid black; width: 20px; text-align: center;"> </td><td style="width: 20px; text-align: center;"> </td></tr><tr><td style="text-align: center;">DD</td><td style="text-align: center;">MM</td><td style="text-align: center;">YYYY</td></tr></table> To: <table style="display: inline-table; border-collapse: collapse;"><tr><td style="border-right: 1px solid black; width: 20px; text-align: center;"> </td><td style="border-right: 1px solid black; width: 20px; text-align: center;"> </td><td style="width: 20px; text-align: center;"> </td></tr><tr><td style="text-align: center;">DD</td><td style="text-align: center;">MM</td><td style="text-align: center;">YYYY</td></tr></table>				DD	MM	YYYY				DD	MM	YYYY	Reason for request (optional): <input type="checkbox"/> Personal <input type="checkbox"/> Support care planning <input type="checkbox"/> Legal <input type="checkbox"/> Insurance form/claim <input type="checkbox"/> Estate <input type="checkbox"/> Tax exemption <input type="checkbox"/> Other (specify):
DD	MM	YYYY											
DD	MM	YYYY											
<input type="checkbox"/> Specific record(s), as outlined below:													

Special instructions

Method/format of release:	
<input type="checkbox"/> Electronic copy – Email address: <input type="checkbox"/> Paper copy to address above <input type="checkbox"/> Paper copy to alternate person and/or address (specify): Name: _____ Mailing address: _____ <input type="checkbox"/> Other (specify): _____	
Is this release time sensitive? <input type="checkbox"/> No <input type="checkbox"/> Yes (specify): _____	
Accommodations required? <input type="checkbox"/> No <input type="checkbox"/> Yes (specify): _____	

 Print Name

 Signature

 Date (DD/MM/YYYY)

The information on this form is collected pursuant to the Personal Health Information Protection Act, 2004 ("the Act"). The information will be used for the purposes of identifying the patient and responding to the request for access pursuant to section 54 of the Act. Questions about this collection should be directed to the Privacy or Health Records contact person at the organization where the request for access is made.