



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 _____ Initials _____

Address _____ Unit _____

City _____ Province _____ Postal Code _____

Telephone _____ Alternate/Cell _____

Substitute Decision-Maker Information:*

Surname _____ Given name _____ Initials _____

Address _____ Unit _____

City _____ Province _____ Postal Code _____

Telephone _____ Alternate/Cell _____

**Please provide documentation to satisfy the Health Information Custodian that you are an authorized Substitute Decision-Maker.*

Please provide a detailed description of the personal health information you are requesting and details that will assist in locating this information (e.g. dates, names of health care provider, etc.)

Preferred method of access to records: Examine Original Receive a Copy

Signature: _____ Date: _____

For Health Information Custodian Use Only:

Date Received: _____ Request Number: _____ Comments: _____