Box 308 Nipigon, ON P0T 2J0

Phone (807) 887-5252 ext. 2

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NDFHT PRIVACY COMPLAINT FORM

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 # _____

Relationship to patient: _____

**Please provide documentation to satisfy the health information custodian that you are an authorized decision-maker, if available.*

Date of the incident that is the reason for this complaint: _____

Please give a brief explanation of your complaint, including dates and names of other people who may be involved. Include copies of relevant material you may have. If you need additional space, please include a separate page.

Complainant's Signature: _____

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.