Box 308 Nipigon, ON P0T 2J0

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REQUEST FOR ACCESS TO PERSONAL HEALTH INFORMATION 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 # ____________________________

**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: _____________________________

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.