Lakeridge Health

Unique #_____

# 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:

_____

**Patient Information**

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss

Surname _____ Given Name _____ Initials _____

Address _____ Unit _____

City _____ Province _____ Postal Code _____

Telephone _____ Date of Birth _____

**Substitute Decision−Maker Information ***

Surname _____ Given Name _____ Initials _____

Address _____ Unit _____

City _____ Province _____ Postal Code _____

Telephone _____ Evening _____

* *Please provide documentation to satisfy the health information custodian that you are an authorized substitute 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 (e.g., dates, name 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 _____

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*. Questions about this collection should be directed to the Privacy Contact Person at the health information custodian where the request for access is made.