



To: Officer-in-charge of _____
(print name of psychiatric facility)

I, _____
(print full name of applicant)

of _____
(address)

request to examine originals
 receive hard copies of originals receive electronic copies of originals (if available)

the personal health information from the records of _____
 _____ (print full name of patient) _____ (date of birth) _____ (casebook no.)

of _____
(address)

Please provide us with details that will help us locate the record (e.g. dates, name of healthcare provider, etc.)

(print name of witness) _____ (signature of patient / Substitute Decision-Maker)
 _____ (signature of witness) _____ (if other than the patient, state relationship to the patient)
Note: We may require copies of documents that provide you with authority as a substitute decision-maker (e.g. POA, will)

 Date (year / month / day)

You have the right to access your personal health information unless a legal exception applies under the *Personal Health Information Protection Act, 2004*.

All requests for access to a record of personal health information must be submitted to Health Information Management.

Response time	Date request received	Date request responded to	For hospital use only
<input type="checkbox"/> response within 30 days of request <input type="checkbox"/> extension beyond 30-day period required			
If an extension to the access request response was required, please indicate:			
Date of extension		Reason for extension	Date patient notified
Response to request			
<input type="checkbox"/> access granted <input type="checkbox"/> access granted in part (specify reason and identify person who instructed partial access)			
<input type="checkbox"/> access denied (specify reason and identify person who instructed access denial)			
Processed by		Signature	Date

