Request to Access Personal Health Information

under the *Personal Health Information Protection Act*, 2004

Joseph Brant Hospital 1230 North Shore Blvd., Burlington ON L7S 1W7
Tel: (905) 632-3730, ext. 5660 Fax: (905) 681-4806

I, ______________________________
(Name of patient, or the substitute decision-maker*)

OF ______________________________
(Complete address)

HEREBY AUTHORIZE ______________________________
(Name of Hospital/Health Care Facility)

TO DISCLOSE PERSONAL HEALTH INFORMATION TO:

NAME: ______________________________
(Examples: patient, family member, doctor, hospital, insurance company, etc.)

ADDRESS: ______________________________

IN RESPECT OF: ______________________________
(Print – Name of Patient)

DATE OF BIRTH: ________________ **HEALTH CARD #:** ________________
(D/ M/YY)

I REQUEST THAT YOU FORWARD THE FOLLOWING INFORMATION FROM THE HEALTH RECORD:

____
(Include treatment date(s) & type of information requested – eg. discharge summary, consults, investigations, etc.)

____

SIGNATURE: ________________ **DATE:** ________________
(Patient or Substitute Decision Maker*)

WITNESS: ________________ ________________
(Print Name) **(Signature)**

***Substitute Decision-Maker's Information:**

NAME OF SUBSTITUTE DECISION MAKER: ________________

RELATIONSHIP TO PATIENT: ________________

ADDRESS: ________________

***Please provide valid documentation to confirm that you are an authorized substitute decision-maker, if applicable.**

For Health Information Use Only:

Date Received: ________________ Chart #: ________________

Comments: ________________

NOTE: Please note that photo I.D. needs to be shown to confirm identity.
Pre-payment for services is required (where applicable).