JOSEPH BRANT HOSPITAL

Request to Access Personal Health Information

under the Personal Health Information Protection Act, 2004

1245 Lakeshore Road, Burlington, ON
Tel: (905) 632-3730, ext. 1465 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: _____

(Patient, Doctor, Hospital, Insurance Company, etc.)

ADDRESS: _____

IN RESPECT OF: _____

(Print – Name of Patient)

DATE OF BIRTH: _____ HEALTH CARD #: _____

(D / M / Y)

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

_____

(Date(s) of treatment – summary, consults, investigations)

_____

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).