Upper Grand Family Health Team

Request for Access to Personal Health Information under the *Personal Health Information Protection Act (PHIPA, 2004)*

Please note: *May be administrative fees associated with providing access to health records. Please ask your physician for more details.*

Patient Contact Information:

Patient Last Name	*First Name*	*Initial*
Birthdate	*Street Address*	
Medical Record Number, if known	*City, Province*	
Telephone Number	*Postal Code*	

Substitute Decision-Maker/Authorized Individual Contact Information (*if applicable*):

Substitute Decision Maker Last Name	*First Name*	*Initial*
Relationship to Patient	*Street Address*	
Telephone Number	*City, Province*	
Note: Include copies of documents that demonstrate your authority as a substitute decision-maker.	*Postal Code*	

May we leave a detailed voice message at the phone number provided ☐ Yes ☐ No

Please describe what you need and include details that will help us locate the record (e.g., dates, name of healthcare provider, etc.). *Attach additional pages if required*.

_____

_____

_____

_____	_____	_____
Signature	*Printed Name*	*Date (DD/MMM/YYYY)*

INTERNAL USE ONLY

If an extension to the access request response is required, please indicate:

_____	_____	_____
Date of Extension	*Reason for Extension*	*Date Patient Notified*

Processed by:

_____	_____	_____
Signature	*Printed Name*	*Date (DD/MMM/YYYY)*

Personal Information contained in this form is collected pursuant to the Freedom of Information and Protection of Privacy Act, R.S.O 1990, c F.31, and will be used for the purpose of responding to your request under the Personal Health Information Protection Act. Questions regarding personal information collection and use should be directed to your physician or the Upper Grand Family Health Team Privacy Officer, at (519) 843-3947 ext. 101.

Revised October 2017