Request to Access Personal Health Information

Client Information

First Name: _____ Last Name: _____

Date of Birth: _____ (DD/MM/YYYY)

Address: _____

Phone: _____ Email: _____

Information Requested

Date(s) and where services provided: _____

_____

Specific personal health information being requested: _____

_____

_____

This is a request to: ☐ examine (view) and/or ☐ receive a copy* of the information described above

This request is for my own information: ☐ Yes ☐ No **If NO – complete the following section**

Substitute Decision Maker for the client (if applicable)

First Name: _____ Last Name: _____

Address: _____

Phone: _____ Email: _____

Indicate your relationship: _____

You may be required to provide documentation to prove you have the legal ability to access these records

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Signature of person making the request: _____

Date of request: _____

Signature of Health Care Provider or their authorized substitute: _____

Date request received: _____

Date of Examination (viewing):_____ Date Copies Provided: _____

*copy fees may apply