

REQUEST FOR ACCESS TO PERSONAL INFORMATION

The information on this form will be used to respond to your request for your personal information or the personal information of someone whom you are legally entitled to represent.

Whose information do you want access to?

- My own personal information.
- Another person's personal information.

Please complete the "Patient Information" and "Authorized Representative's Contact Information" sections below, and attach proof that you can legally act on behalf of that individual.

Patient information

Mr / Mrs / Ms (please circle)

Street address:

Last name: _____ City /town: _____
Prov. _____

First name: _____ Postal code: _____
Fax: _____

Health Card number: _____ Tel: (home) _____ (bus)

Date of birth (dd/mm/yy): _____ Email address:

Please describe, in as much detail as possible, the information you want ~~to~~ access to. Indicate if you also want access to records about the disclosure of your information, or information of the person you are representing. Be sure to give previous names, if any.

Please indicate if you wish to:

- Receive a photocopy of the record.

Please note that a base fee of \$_____ per page applies for each page copied. For convenience, you may enclose this fee with your request. You will be provided with an estimate of any additional costs.

- View the original record, without receiving a copy.
Please ask for an estimate of the fee you will be charged for:
 - Review of the original by the physician **and / or**
 - Supervision by physician or designated staff person for your review

A deposit of the fee(s) may be required.

X _____

Patient Signature

Date (dd/mm/yy)