

MRN:			

Form to Request Access To Personal Health Records

Information and Instructions

We will provide you with access to your personal health record, unless a legal exception applies. We review all health record access requests and make every effort to respond to your request in a timely fashion. Please complete Parts A and B of this Form. Part C is for our internal use. For information about our privacy protection practices, contact the Privacy Officer at: 170 Colborne Street W., Orillia, ON, L3V 2Z3 tel: (705) 325-2201, ext.3626 Fax: (705) 325-8652 Email: privacy@osmh.on.ca

PART A: PATIENT & REQUESTOR INFORMATION

Patient Information		
Patient's Last Name	First Name	Middle Initial
Telephone Number	Date of Birth	
Mailing Address		
If you are the patient's substit	ute decision-maker, your contact	information:
Last Name	First Name	
Telephone Number		
Relationship to the patient		

Note: Include copies of documents that provide your authority as a substitute decision-maker (such as Power of Attorney for Personal Care, Will, Custody paperwork)



MRN:			

PART B: DETAILS OF ACCESS REQUEST

	ords you are requesting, and include (s), name of healthcare provider, et	e any details that will help us locate the record c.).
-		
How would you pre	efer to access this information? Ple	ease check:
	Receive hard copies of originals	
	Examine originals in the facility	
Signature	Name (print)	Date
Witness Signature	 Witness Name (pr	int) Date



MRN:			

	ed equest granted		
Access r	equest granted		
Access r			
	equest not granted		
Access r	equest granted in part		
=	request was not granted, re	eason for refusing the request/pa	rt of the
rmation Regard	ling Extension		
to the access re	equest response was require	ed, please indicate:	
nsion	Reason for Extension	Date Patient Notified	
	rmation Regard	rmation Regarding Extension to the access request response was require	rmation Regarding Extension to the access request response was required, please indicate:

Signature

Name (print)

Title