Request to Access Personal Health Information (PHI)

under the Personal Health Information Protection Act, 2004

Client Information

Last Name _____ First Name _____ Birthdate: _____

Address _____ Unit: _____

City _____ Province _____ PostalCode _____

Contact # _____ Alt Contact # _____

Parent/Legal Guardian

Last Name _____ First Name _____ Initials _____

Address _____ Unit: _____

City _____ Province _____ PostalCode _____

Contact # _____ Alt Contact # _____

*Please provide documentation to show that you are authorized to receive this information if other than the legal guardian.

Please provide a detailed description of the personal health information you are requesting and details that will assist in locating this information (e.g., location and dates of treatment, health care provider name, etc.).

Preferred method of access to records: ☐ Examine Original ☐ Receive a Copy

Client Signature: _____

Signature: _____ Date

Relationship: _____

03/2021

BETTER OUTCOMES. TOGETHER.
KINARK
CHILDREN AND YOUTH

Client Name:_____
Client ID#: _____

For Office Use Only

Date Received _____ Date Completed _____

Comments:

File completed form and copy of response letter in the client information system.

The personal health information contained on this form is collected pursuant to the Personal Health Information Protection Act, 2004 ("the Act") and will be used for the purpose of responding to your request for access pursuant to section 54 of the Act. Questions about this collection should be directed to the Privacy Contact person (Lori.Claxton@kinark.on.ca).