



# 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 (SDM)

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: \_\_\_\_\_

SDM Signature: \_\_\_\_\_ Date \_\_\_\_\_

Relationship: \_\_\_\_\_



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.