



- Douglas Memorial Site
- Niagara-on-the-Lake Site
- Ontario Street Site
- Welland Site
- Greater Niagara General Site
- Port Colborne General Site
- St. Catharines General Site

Cost: \_\_\_\_\_  
 Date Released: \_\_\_\_\_  
 Hospital Unit No.: \_\_\_\_\_

DD / MM / YY

### REQUEST FOR ACCESS TO PERSONAL HEALTH INFORMATION

Information and Instructions

We will provide you with access to your personal health record, unless a legal exception applies. We will review all health record access requests, and will make every effort to respond to your request in a timely fashion. For information about our privacy protection practices, contact NHS Privacy Office at 905-378-4647 Extension 44475.

Patient/Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(Last name and First name) DD/MM/YY

Address: \_\_\_\_\_ Prov. \_\_\_\_\_ Postal Code: \_\_\_\_\_

Tel. Home #: ( ) \_\_\_\_\_ Tel. Work #: ( ) \_\_\_\_\_

Substitute Decision Maker Name: \_\_\_\_\_  
(Name & Relationship to Patient)

Address: \_\_\_\_\_ Tel #: ( ) \_\_\_\_\_

**NOTE: Include copies of documents that provide your authority**

**ACCESS REQUEST:** Please describe what you need and include details that will help us locate the record (ie – dates, name of healthcare provider etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How would you prefer to access this information?  Receive hard copies of originals  Examine originals in the facility

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
DD/MM/YY

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
DD/MM/YY

**RESPONSE TO ACCESS REQUEST (For Internal Use Only)**

Date Request Received: \_\_\_\_\_ Date Response Issued: \_\_\_\_\_  
DD/MM/YY DD/MM/YY

- Access request granted
- Access request not granted
- Access request granted in part (notify NHS Chief Privacy Officer by mail)

If complete access was not granted, give reason(s) for refusing the request/part of the request.

Information Regarding Extension

If an extension to the access request response was required, notify the NHS Chief Privacy Officer by mail:

Date of Extension: \_\_\_\_\_ Date Patient Notified: \_\_\_\_\_  
DD/MM/YY DD/MM/YY

Reason for Extension: \_\_\_\_\_

Processed by: \_\_\_\_\_  
Signature Print Name Title