



Request for Access to Personal Health Information

We will provide you with access to your personal health record, unless a legal exception applies. We accept requests from the individual to whom the information relates or that individual's substitute decision maker.

Please complete this side of the form. The reverse side is to be completed by the staff member(s) processing the request.

Organization being asked to provide access	
<input type="checkbox"/> St. Joseph's Villa	<input type="checkbox"/> St. Joseph's Continuing Care Centre
<input type="checkbox"/> Villa St. Gabriel Villa	<input type="checkbox"/> St. Joseph's Health Centre

Person whose information will be accessed				
		Date of birth		
Last Name	First name	DD	MM	YYYY
This person is:				
<input type="checkbox"/> a current resident <input type="checkbox"/> a current patient <input type="checkbox"/> a former resident <input type="checkbox"/> a former patient				

Information about the requestor		
Name	I am the:	<input type="checkbox"/> Patient/Resident's Attorney <input type="checkbox"/> Insurance Company <input type="checkbox"/> Other: _____
<input type="checkbox"/> Patient/Resident	<input type="checkbox"/> Substitute Decision Maker/POA	
Street address	Daytime phone number	
City and province	Postal code	Evening phone number

Information being requested (For example, you may request access to a medication list. <i>Note: A fee may apply.</i>)	
Type of document	Date on the document

Preferred method of access		
<input type="checkbox"/> Examine originals in the facility	<input type="checkbox"/> Receive copies in person	<input type="checkbox"/> Receive copies by registered mail

***Please note that the organization has 30 days to respond to requests, as per the *Personal Health Information Protection Act, 2004*.**

Signature	Date
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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 Officer by calling 705-674-2846, ext. 2029 or by emailing privacy@sjshd.com.

Person who received the request:		Date the request was received:		
_____		_____	_____	_____
Name		DD	MM	YYYY

Person who coordinated the response to the request:		Date the request was reviewed:		
_____		_____	_____	_____
Name		DD	MM	YYYY

Timeframe for response
<input type="checkbox"/> Response provided within 30 days of date request received.
<input type="checkbox"/> Extension required, response provided within 60 days of date request received.*

* Attach any formal correspondence which specifies rationale for requiring an extension.

Decision	Method of access provided
<input type="checkbox"/> Access request granted	<input type="checkbox"/> Information provided verbally over the telephone
<input type="checkbox"/> Access request granted in part*	<input type="checkbox"/> Original information examined in person
<input type="checkbox"/> Access request denied*	<input type="checkbox"/> Copies provided in person
	<input type="checkbox"/> Copies sent by registered mail
* Attach any formal correspondence which specifies rationale for granting only part of the request or for denying access.	
Person who provided the information:	

Name	
Date access provided:	

DD MM YYYY	

Fees				Date fees collected and sent to Finance:		
_____	_____	_____	_____	_____	_____	_____
Admin Fee	# of copies \$0.20/copy	Courier Cost	Amount	DD	MM	YYYY