ATIKOKAN GENERAL HOSPITAL

Health Records Department
P.O. Box 2490, 120 Dorothy Street
Atikokan, ON P0T 1C0
Phone (807) 597-4215, Ext. 291
Fax (807) 597-1210

Request to Access, or Disclose, Personal Health Information

Instructions:

- Complete Parts A and B of this form with as much information as possible.
- Requests will only be accepted from the patient, or someone that the patient has asked to make the request, (ie. Substitute decision maker). If we don't know you, or are unsure whether the patient has asked you to make the request, you will need to provide photo identification, and prove that the patient has allowed you to make the request.
- Ontario law (PHIPA) allows Atikokan General Hospital to charge administrative fees when individuals request a copy of their personal health information. We may request you pay a fee prior to processing your request.
- Your request will be reviewed and every effort will be made to respond to your request within 30 days.
- Your request will be filed in a secure filing cabinet in the Health Records Department.
- For more information about our privacy protection practices, please contact our Privacy Officer.

PART A: Patient Identification

Last Name _____ First Name _____ Initials _____

Mailing Address _____

Telephone Number _____ Date of Birth _____

If you are a substitute decision-maker (SDM), your contact information:

Last Name _____ First Name _____ Initials _____

Mailing Address _____

Telephone Number _____ Relationship _____

Note: Include copies of documents that prove your authority as a substitute decision-maker.

Office Use Only – Verification of identity of individual consenting to access/disclosure:

Form of ID: ☐ Drivers License ☐ Passport ☐ Notarized Letter/Lawyer's letter

☐ Other, specify: _____

ID Verified by: _____ _____
Print Name Signature

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PART B: Information to be Accessed or Disclosed

1. Describe the information you need and include details that will help us locate the record.

Date(s) of Service and Level of Care: _____

_____

_____

Description of Personal Health Information Requested: _____

_____

_____

Healthcare Provider(s) and Healthcare Organization(s): _____

_____

I understand that this information is to be used by the Recipient for the purpose of: _____

_____

2. Indicate who you are consenting, or authorizing, to receive the information described:

☐ **Self** How would you prefer to access this information? ☐ Receive hard copies ☐ Examine originals at the facility

☐ **Third Party, or other** -- Provide recipient details below:

_____ _____
Name Organization

_____
Mailing Address

_____ _____
Phone Number Fax Number, if applicable

I hereby authorize the Atikokan General Hospital to release the above personal health information and waive any and all claims against Atikokan General Hospital in connection with the disclosure of this personal health information.

_____ _____
Signature: Patient, or SDM Date

_____ _____
Witness Signature Print Witness Name

Please note:

- This authorization will be considered valid for a period of up to three months from the date of signing unless otherwise stated.
- This Consent pertains to the disclosure of information that is specific to treatment received on or before the date signed. It can be altered or withdrawn by the patient or alternate at any time by written notification to the hospital. Withdrawal of consent is not retroactive to information already released.