AHCS
Atikokan Health and Community Services

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

Information:
- This form is used by patients or their authorized decision makers to request access to the patient's health record.
- Your request will be reviewed and every effort will be made to respond to your request within a timely fashion.
- In rare situations, you may be denied access to some or all of your record (in accordance with applicable law).
- For more information about our privacy protection practices, please contact our Privacy Officer.

PART A: Patient Identification

Last Name _____ First Name _____ Maiden/Other Name _____

Date of Birth (dd/mm/yyyy) _____ Telephone Number _____

Mailing Address _____

PART B: Information to be Accessed or Disclosed

Please describe what you need and include details that will help us locate the record (e.g. dates, names of healthcare provider, etc.)

_____

_____

_____

PART C: Substitute Decision Maker (If Applicable)

If you are not the patient listed above, but are making this request on behalf of the patient, please fill in your contact information. Include copies of documents that prove your authority as a substitute decision-maker.

Last Name _____ First Name _____

Telephone Number _____ Relationship to Patient _____

Mailing Address _____

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PART D: AUTHORIZATON

Indicate who you are consenting or authorizing to receive the records:

☐ Self

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

Name _____ Organization _____

Mailing Address _____

Phone Number _____ Fax Number, if applicable _____

How would you prefer to access this information?

☐ Receive hard copies ☐ Examine originals at the facility

The purpose of this request is:

☐ Continuing Care ☐ Legal ☐ Insurance ☐ Personal Use

(Please note there is a fee for records for non-medical use)

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

Signature: Patient or SDM _____ Date _____

Witness Signature _____ Print Witness Name _____

This authorization will be considered valid for a period of up to 90 days 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.