WOMEN'S COLLEGE HOSPITAL
Health care for women | REVOLUTIONIZED
76 Grenville Street, Toronto, ON M5S 1B2

HEALTH INFORMATION DEPARTMENT ACCESSING PERSONAL HEALTH INFORMATION

PATIENT IDENTIFICATION

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. Please complete Parts A and B of this form. Part C is for our internal use. For further information please contact the Release of Information Specialist in the Health Information Department at: 416-323-6098 or you can visit us at 76 Grenville Street, Room P1-208, Toronto, Ontario M5S 1B2. Please note that our general business hours is from Monday to Friday, 8:00am to 4:00pm.

PART A: REQUESTOR INFORMATION

PATIENT CONTACT INFORMATION:

Last name: _____ First name: _____ Initials: _____

Mailing address: _____

Telephone number: _____ Date of birth: _____/___/___
YYYY/MM/DD

Hospital ID number: _____ Health Card Number: _____

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

Last name: _____ First name: _____ Initials: _____

Mailing address: _____

Telephone number: _____

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

PART B: ACCESS REQUEST

1. Please describe what you need and include details that will help us locate the record (e.g.,

   dates, name of healthcare provider, etc.).

   _____

   _____

   _____

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2. How would you prefer to access this information? Please check off:
   - ❑ Receive hard copies of originals
   - ❑ Examine originals in the facility

Print Name: _____ Signature: _____ Date: _____/___/___
YYYY/MM/DD

PART C: RESPONSE TO ACCESS REQUEST (FOR INTERNAL USE ONLY)

1. INFORMATION REGARDING RECEIPT AND INITIAL REVIEW OF REQUEST

Date request received: _____/___/___
YYYY/MM/DD

2. INFORMATION REGARDING RESPONSE

Date response issued: _____/___/___
YYYY/MM/DD

- ❑ Access request granted
- ❑ Access request not granted
- ❑ Access request granted in part

3. INFORMATION REGARDING EXTENSION

If an extension to the access request response was required, please indicate:

Date of extension:	Reason for extension:	Date patient notified:
_____/___/___ YYYY/MM/DD		_____/___/___ YYYY/MM/DD

4. PROCESSED BY:

Print Name: _____ Signature: _____ Title: _____