



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:      /      /       
 YYYYY/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:     /    /      
 YYYYY/MM/DD

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

**1. INFORMATION REGARDING RECEIPT AND INITIAL REVIEW OF REQUEST**

Date request received:     /    /      
 YYYYY/MM/DD

**2. INFORMATION REGARDING RESPONSE**

Date response issued:     /    /      
 YYYYY/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:
<u>    </u> / <u>    </u> / <u>    </u> YYYYY/MM/DD		<u>    </u> / <u>    </u> / <u>    </u> YYYYY/MM/DD

**4. PROCESSED BY:**

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Title: \_\_\_\_\_