

Request Form

under the *Freedom of Information and Protection of Privacy Act*
Please Note: A \$5.00 application fee is required for all requests

Request for: <input type="checkbox"/> Access to General Records <input type="checkbox"/> Access to Own Personal Information <input type="checkbox"/> Correction to Own Personal Information	Name of Institution request made to: Women's College Hospital 76 Grenville Street Toronto, ON M5S 1B2
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If request is for **access to**, or **correction of**, own personal information records:

Last name appearing on records: same as below, or: _____

___Mr. ___Mrs. ___Ms. ___Miss Last Name: _____

First Name: _____ Middle Name: _____

Address: _____ City/Town: _____

Province: _____ Postal Code: _____

Telephone Number (Day): () _____ Other Number: () _____

Detailed description of requested records, personal information or personal information to be corrected. (If you are requesting access to or correction of your personal information, please identify the personal information bank or record containing the person information, if known.)

Note: If you are requesting a correction of personal information, please indicate the desired correction, and if appropriate, attach any supporting documentation. You will be notified if the correction is not made and you may require that a statement of disagreement be attached to your personal information.

Preferred method of access to records	<input type="checkbox"/> Examine Original <input type="checkbox"/> Receive Copy	Signature: _____	Date: _____
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For Institution Use Only		
Date Received:	Request Number:	Comments: