



Patient or SDM (Substitute Decision Maker) Request to Access Personal Health Information

I request access to the following information:

(Patient/SDM (Substitute Decision Maker))

Information pertaining to: (Detail of information to be released (dates, type of visit, other information as required))

| | | | |
|-----------|------------|---------------|--------------------|
| | | | |
| Last Name | First Name | Date of Birth | Health Card Number |

Patient/SDM* requesting access:

| | | | | |
|-----------|------------|--|-----------|-----------------|
| | | | | |
| Last Name | First Name | Relationship if other than patient (if patient is incapable or deceased) | Signature | Date (yy-mm-dd) |

Contact Information

| | | | | |
|---------|------|-------------|---------|-------------|
| | | | | |
| Address | City | Province | Country | Postal Code |
| | | | | |
| Email | | Telephone # | Fax # | |

*Authorized substitute decision-maker will be required to provide the documentation to satisfy the health information custodian.

Please provide one of the following pieces of ID to receive the requested information.

Records can be obtained from the Health Records Department.

Driver's License
 Passport
 Health Card (with photo)

Please Note: The fee is \$30 + tax = \$33.90 for up to 20 pages. Every additional page after that is \$0.25. Payment is due upon receipt.

This Consent For Disclosure is valid for 6 months and 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 It can be altered or withdrawn by the patient or SDM at any time by written notification to the hospital. Withdrawal of consent is not retroactive to information already disclosed.

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| <p>Listowel Memorial Hospital Health Records Department 255 Elizabeth St. East Listowel, ON N4W 2P5 Phone: (519)291-3120 Ext. 6207 Fax: (519)292-2131</p> | <p>Wingham and District Hospital Health Records Department 270 Carling Terrace Wingham, ON, N0G 2W0 Phone: (519)357-3210 Ext. 5230 Fax: (519)357-3904</p> |
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