St. Joseph's Healthcare Hamilton

Request for Access to Personal Health Information

Information and Instructions

Only the patient, the substitute decision maker (SDM) or legal representative may make requests to access patient personal health information. We provide access to personal health information, unless a legal exception applies. We review all health record access requests, and make every effort to respond to each request within thirty (30) days of receipt of the request. Please complete Parts A and B of this Form.

1. This authorization is valid for three (3) months from date of signature and must contain:
   - the original signature of the patient or substitute decision maker (SDM)
   - the legal representative if the patient is deceased
   - the signature of the witness to the patient or SDM signature
2. Requests for access to information must be dated after treatment dates.
3. Deliver completed request to appropriate Release of Information Specialist (address below)

For information about our privacy protection practices visit our website at www.stjoes.ca/privacy

Part A: Requestor Information
Patient Contact Information:

Name: ______________________________ Initials: __________
First Last

Address: ______________________________
Street City Postal Code

Telephone Number: (   )__________ Date of Birth__________ Hospital ID Number: ________
yyyy/mm/dd

If you are the substitute decision maker (SDM), please provide your contact information:

Name: ______________________________ Initials: __________
First Last

Address: ______________________________
Street City Postal Code

Telephone Number: (   )______________

NOTE: Please be sure to include copies of documents that confirm your authority as a substitute decision maker

Part B: Access Request

1. Please describe what information you are looking for and include details that will help us locate your record (Example: dates, name of healthcare provider, etc.).

____

____

2. How would you prefer to access this information? Please indicate with a checkmark.
   - ❑ Receive hard copies of originals
   - ❑ Review originals in the facility

   NOTE: there is a charge for copies and there may be a charge for review

Signature	Printed Name	Title (if applicab	Date (yyyy/mm/dd)

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For Internal Use Only

Part C: Response to Access Request

1. **Information regarding receipt and initial review of request:**

   Date Request Received: ______________________________
   yyyy/mm/dd

   Date Request Forwarded to Health Care Provider for Review: ______________________________
   yyyy/mm/dd

   Date Request (Not) Approved:
   - ❑ Access request granted
   - ❑ Access request partially granted
   - ❑ Access request NOT granted

2. **Information regarding response:**

   Date Response Issued: ______________________________
   yyyy/mm/dd

   If complete access request was NOT granted, reason for refusing the request/part of the request:

   ____

   ____

3. **Information Regarding Extension**

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

Date of Extension (yyyy/mm/dd)	Reason for Extension	Date Patient Notified (yyyy/mm/dd)

4. **Processed By:**

Signature	Printed Name	Title

Charlton Campus
50 Charlton Ave., East
Hamilton, ON, Canada L8N 4A6
Tel: 905.522.1155

King Campus
2757 King Street East
Hamilton, ON, Canada L8G 5E4
Tel: 905.522.1155

West 5th Campus
100 West 5th Street
Hamilton, ON, Canada L8N 3K7
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Member, St. Joseph's Health System
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