



Access/Correction Request for Personal Health Information

Personal Health Information Protection Act, 2004 (PHIPA)

SECTION 1 – Type of Request				
<input type="checkbox"/> Access to Own Personal Health Information <input type="checkbox"/> Access to Other’s Personal Health Information by Authorized Party <input type="checkbox"/> Correction of Personal Health Information	Submit Request to: The Regional Municipality of York Community and Health Services Integrated Business Services Branch Program Manager, IMAP 520 Cane Parkway Newmarket, ON L3Y 8T5 or Fax to:(905)895-3149			
SECTION 2 – Personal Health Information is being requested for:				
	Last Name	First Name	Date of Birth (yy/mm/dd)	
<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Miss				
Location with custody of Records (i.e. Department, program, facility)		Request for specific time period		
		Start Date (yy/mm/dd)	End Date (yy/mm/dd)	
Please provide a detailed description of requested personal health information records to be disclosed or corrected by The Regional Municipality of York along with supporting documentation, if applicable.				
SECTION 3 – Requester Information if differs from Section 2				
	Requester’s Last Name		Requester’s First Name	
<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Miss				
Address		City/Town	Province	Postal Code
Telephone Number:	Day Contact # ()		Cell # ()	
<input type="checkbox"/> I am the individual who’s personal health information is being requested <input type="checkbox"/> I am the parent with custody, or a person lawfully entitled to consent on behalf of individual in Section 2 <input type="checkbox"/> I am exercising a power of attorney for the individual in Section 2 and have attached a copy of the supporting documentation. <input type="checkbox"/> The individual in Section 2 is deceased and I am an estate trustee or have assumed responsibility for the administration of the deceased's estate and I have attached a copy of the supporting documentation.				
Signature of Requestor			Date (yy/mm/dd)	
SECTION 4 – For Internal Use Only				
Date Received: (yy/mm/dd)		File Number:	Request Received and Processed By:	
Personal health information contained on this form is collected under section 53 of the <i>Personal Health Information Protection Act, 2004</i> , and will be used to respond to your request. Questions about this collection should be directed to The Regional Municipality of York, Program Manager, Community and Health Services, Information Management, Access and Privacy (IMAP) Telephone: 1-877-464-9675 ext. 74506.				
<i>This request may be subject to Fees</i>				