Waypoint Centre for Mental Health Care
Request for Access / Copies of Personal Health Information

Patient Name: ____________
Place Patient Identifier Label Here
Account Number: ____________

To: ____________________________
(name of psychiatric facility)

I, ____________________________
(print full name of applicant) (phone number)

____
(address) (email address)

Request to:
- ☐ Examine my record of personal health information
- ☐ Receive paper copies of personal health information (complete page 2)
- ☐ Receive electronic copies of personal health information (complete page 2)

The personal health information from the records of:

____
(print full name of patient) (date of birth D/M/Y) (health card number and version code)

____
(signature of patient) (date D/M/Y)

____
(if other than the patient, state relationship to the patient)

Note: If you are the patient's Substitute Decision Maker (SDM), please include a copy of the document(s) that authorize you as the SDM.

You have the right to access your personal health information unless a legal exception applies under the Personal Health Information Protection Act, 2004.

For Hospital Use Only

Date request received by Health Information Management: ____________
(date D/M/Y)

Has the patient record been reviewed by the Program Manager, Psychiatrist, Clinician, or delegate: ☐ Yes ☐ No

Date of patient record review: ____________
(date D/M/Y)

Does an exemption apply? ☐ Yes ☐ No
If yes, please contact the Privacy Office to discuss the rationale.

Name of Program Manager confirming patient record review and authorizing Health Information Management to proceed with the access request: ____________
(name)

Received in HIM by: ____________ for processing on: ____________
(CHIM) (date D/M/Y)

Patient Name: ____________
Place Patient Identifier Label Here
Account Number: ____________

To: ______________________________
(name of psychiatric facility)

____
(print full name of patient) (health card number and version code)

I, ______________________________
(print full name of applicant)

hereby request photocopies of the clinical record with respect to:

Section of clinical record	Reports to be copied	Date of report (D/M/Y)

____
(signature of applicant) (if other than the patient, state relationship to the patient)

Requestor acknowledges receipt of copies:

____
(signature) (date D/M/Y)

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