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

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

Information and instructions:
We will provide you with access to your personal health record unless a legal exception applies. We will review all health record access requests and will make every effort to respond to your request in a timely manner. If you are requesting access to **your own health record**, please complete Sections A and B. If you are requesting access to **someone else's health record**, please complete Sections A, B, and C.

Section A: Patient Information

Last Name	First Name	Date of Birth (d/m/y)

Full Address (number, street, city, province, postal code)

Phone Number	Email Address

Section B: Access Request

I am requesting access to:

- ☐ View the original electronic health record at Waypoint
- ☐ Receive electronic copies from the health record
- ☐ Receive paper copies from the health record

Name of Document(s) / Document Type(s) to be Viewed or Copied	Date of Document(s)

Section C: Substitute Decision Maker Information (If Applicable)

Last Name	First Name	Date of Birth (d/m/y)

Full Address (number, street, city, province, postal code)

Phone Number	Email Address

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

Patient/Requestors Signature	Patient/Requestors Name (Print)	Date

For Hospital Use Only

Has the patient record been reviewed: Yes No Date of review: _____ (d/m/y)

Clinician Name: _____

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