CAMPBELLFORD MEMORIAL HOSPITAL

Request to Access Personal Health Information

Under the Personal Health Information Act (PHIPA)

PART A: REQUESTOR INFORMATION – PATIENT CONTACT INFORMATION

Last name: _____ First Name: _____ Middle Name(s):_____

Address: _____

City: _____ Province: _____

Postal Code: _____ Telephone: _____

If you are a substitute decision-maker, your contact information:*

*NOTE: We require copies of documents (POA for Personal Care or Will) that provide your authority as a substitute decision-maker or executor.

Last name: _____ First Name: _____ Middle Name(s):_____

Address: _____

City: _____ Province: _____

Postal Code: _____ Telephone: _____

PART B: ACCESS REQUEST

1. In order to help us locate the records, please describe what you need (i.e. dates, name of healthcare provider, etc.)_____

I hereby waive any and all claims against Campbellford Memorial Hospital in connection with the disclosure of this personal health information.

Signature: _____ Date: _____