

# Freedom of Information Request Form

Under the Freedom of Information and Protection of Privacy Act



Providence Healthcare  
St. Joseph's Health Centre  
St. Michael's Hospital

**Instructions:** A \$5 application fee is required. Make cheques or money orders payable to St. Michael's Hospital (for requests for information related to any Unity Health site, including Providence, St. Joseph's and/or St. Michael's). Mail the cheque and completed form to: Privacy Office, Unity Health Toronto, c/o St. Michael's Hospital, 30 Bond St. Toronto, ON M5B 1W8

## Requester's Information (please print)

Last Name	First Name	Organization (if applicable)
Mailing Address (Street, apartment #, or PO box)		
City	Province	Postal Code
Daytime Telephone Number	May we leave a voicemail at this number? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Email Address	<b>Note:</b> Email communication is not secure. Emails can be intercepted, viewed, changed or saved by others. By providing your email address you consent to be contacted by email about the details of your request. Unity Health reserves the right to determine the format in which records will be released.	

## Type of Request

Request for: <input type="checkbox"/> Access to general records <input type="checkbox"/> Access to own personal information <input type="checkbox"/> Correction to own personal information	For records in the custody of: <input type="checkbox"/> Providence Healthcare <input type="checkbox"/> St. Joseph's Health Centre Toronto <input type="checkbox"/> St. Michael's Hospital
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## Description of Records

Make your request as clear and specific as possible. Provide as much detail as possible to specify which records you require. If possible, provide a date or time period for the records you are requesting. Use a separate sheet of paper if you need more space and attach it to this form.

**All requests for personal information will require proof of identification before information can be released.**

Time period of the records:  From (yyyy/mm/dd)      To (yyyy/mm/dd)	Preferred method of access: <input type="checkbox"/> Receive a copy <input type="checkbox"/> Examine original (on site only)
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## Signature

Signature

Date

Personal Information contained on this form is collected pursuant to the Freedom of Information and Protection of Privacy Act and will be used for the purpose of responding to your request. Questions about this collection should be directed to the Privacy Office at Unity Health Toronto at 416-864-6088 or [fippa@smh.ca](mailto:fippa@smh.ca)