PROVIDENCE
UNITY HEALTH TORONTO

To: Health Records Department
3276 St. Clair Avenue East
Toronto, Ontario M1L 1W1
Tel: (416) 285-3666
Fax: (416) 285-3635
E-mail: healthrecordsPHC@unityhealth.to

Request for Access to Personal Health Information under the *Personal Health Information Protection Act*

***Please note: Fee** for requesting **copies** (except for continuation of care): **$30.00** (includes first 20 pages) and **$0.25 per additional page**, plus **HST**. Other charges may apply as per Providence Healthcare policy.*

Patient Contact Information:

(Patient Last Name)	(First Name)
(Birth Date)	(Ontario Health Number)
(Street Address)	(City, Province)
(Postal Code)	(Telephone Number)

Substitute Decision-Maker/Legally Authorized Individual Contact Information (if applicable):

(Last Name)	(First Name)
(Relationship to Patient)	(Street Address)
(City, Province)	(Postal Code)
***Note*: Include copies of legal documents that demonstrate your authority as a **Power of Attorney or Executor of Estate**.**	(Telephone Number)

May we leave a detailed voice message at the phone number provided ☐ Yes ☐ No
Personal health information to be disclosed (**select one**): View only ☐ Requesting copies ☐

Personal Health Information Authorized for Release

Description of personal health information and dates (if known) to be disclosed:

☐ Complete Health Record (date of admission and discharge) _____
☐ Admission Note (date if known) _____
☐ Final Note (date if known) _____
☐ Lab and Test Results (Specify) _____
☐ Consultation Note(s) (Specify) _____
☐ Other (Specify) _____

Personal Health Information Disclosed To:

☐ Self
☐ Authorized representative (Please specify) _____
☐ Other (Please specify) _____

This authorization is valid for a period of 90 days from the date of signing. It may be revoked or amended in writing during that period except where action has been taken based on authorization provided. This authorization shall apply only to information dated before the date of the signature. I hereby waive any and all claims that I may have against Providence Healthcare in connection with the disclosure of this personal health information to the Recipient.

Signed by: _____ Witness: _____
(Patient or Substitute Decision-Maker)

_____ Date: _____
(Relationship, if other than Patient)