Request to Access and Disclosure of Personal Health
Under the Personal Health Information Protection Act, 2004

DATE (YYYY/MM/DD) _____

YOUR INFORMATION (name on the clinical record):

SURNAME _____ GIVEN NAME _____ INITIALS _____

ADDRESS _____ UNIT _____

CITY _____ PROVINCE _____ POSTAL CODE _____

TELEPHONE _____

SUBSTITUTE DECISION-MAKER INFORMATION*

SURNAME _____ GIVEN NAME _____ INITIALS _____

ADDRESS _____ UNIT _____

CITY _____ PROVINCE _____ POSTAL CODE _____

TELEPHONE _____ RELATIONSHIP _____

** Please note that you may be asked to provide documentation to satisfy that you are the substitute decision-maker.*

IN THE SPACE BELOW, PLEASE PROVIDE A DETAILED DESCRIPTION OF THE PERSONAL HEALTH INFORMATION YOU ARE REQUESTING.

SIGNATURE _____
(Substitute Decision Maker)

SIGNATURE _____ DATE _____
(Child/Youth)

Note: You have the right to access your personal health information at Wellkin, unless a legal exception applies under the Personal Health Information Protection Act, 2004. Wellkin has 30 days to respond to your initial request for access.

Please send the completed form to Wellkin via email at info@wellkin.ca or by fax at 519-539-7058.

For questions, please call 1-877-539-0463 and ask to speak to a member of the Data and Administration Team.

Form Updated: June 30, 2023