Return completed form to: _____

APPENDIX A

PATIENT, SDM (Substitute Decision Maker) OR EXECUTOR REQUEST TO ACCESS PERSONAL HEALTH INFORMATION

I, _____REQUEST ACCESS TO THE FOLLOWING INFORMATION:

(Patient or SDM)

(specify dates of visits, contacts, hospitalization, treatment, or other information as required)

FROM: South Huron Hospital

PERTAINING TO: PIN #_____

Patient / Client Name: _____ Date of Birth: _____
Last Name Given Name Middle Name (YYYY / MM / DD)

Address: _____

_____ Telephone #: _____

This information will be for the purpose of: ☐ Personal Use/Copy ☐ Legal Copy ☐ Ongoing Care

Patient/SDM/Executor requesting access:

Printed Name: _____ Signature: _____

Relationship if other than patient**:** Address & Telephone # if different than patient

_____ _____

DATE: (YY/MM/DD) _____

Office Use only - Verification of identity of individual requesting access:

Form of ID: ❑ Drivers License ❑ Passport ❑ Notarized letter/Lawyer's letter

❑ Other (specify) _____

ID validated by _____ _____
Printed name Signature

PLEASE NOTE: This Request to Access, is valid for 6 months from date of signing and pertains to the information that is specific to treatment received on or before the date signed. It can be altered or withdrawn by the patient, SDM (Substitute Decision Maker) or Executor at any time by written notification to the Hospital. Withdrawal of request is not retroactive to information already accessed.