Access Request for Personal Health Information

INFORMATION & INSTRUCTIONS

We will provide you with access to your personal health record, unless a legal exception applies. We will review all access requests, and will make every effort to respond to your request in a timely fashion. **Please complete Parts A and B of this Form**. Part C is for our internal use. An administrative fee of $25 will be levied for each access request. Please include a cheque made out to the Ontario Telemedicine Network with your request. For questions about this form or our privacy practices, please contact the OTN Privacy Officer at privacy@otn.ca or call **1.866.454.6861**.

PART A: PERSON REQUESTING INFORMATION

SURNAME | GIVEN NAME | INITIALS

MAILING ADDRESS | CITY | PROVINCE | POSTAL CODE

TELEPHONE (Home/Work) | DATE OF BIRTH (DD/MM/YY) | OTN ID # (if known by patient)

SUBSTITUTE DECISION-MAKER CONTACT INFORMATION (include copies of documents that detail or confirm your authority as a substitute decision-maker)

SURNAME | GIVEN NAME | INITIALS

MAILING ADDRESS | CITY | PROVINCE | POSTAL CODE

TELEPHONE (Home) | TELEPHONE (Work)

PART B: ACCESS REQUEST

Please describe what you need & include details that will help us locate the record (e.g., dates, name of healthcare provider. etc.)

Hard copies of information will be mailed to you at the mailing address you have provided on this form unless otherwise specified.

SIGNATURE | PRINT NAME | DATE (DD/MM/YY)

On completion of this form, your privacy complaint should be sent to:
Privacy Officer, Ontario Telemedicine Network, 105 Moatfield Drive, Suite 1100, Toronto, Ontario M3B 0A2

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PART C: RESPONSE TO ACCESS REQUEST (for internal use only)

INFORMATION REGARDING RECEIPT AND INITIAL REVIEW OF REQUEST

DATE REQUEST RECEIVED (DD/MM/YY)

INFORMATION REGARDING RESPONSE

DATE RESPONSE ISSUED (DD/MM/YY)

○ ACCESS REQUEST GRANTED ○ ACCESS REQUEST NOT GRANTED ○ ACCESS REQUEST GRANTED IN PART

IF COMPLETE ACCESS REQUEST WAS NOT GRANTED, REASON FOR REFUSING THE REQUEST PART OF THE REQUEST:

IF AN EXTENSION TO THE CORRECTION REQUEST RESPONSE WAS REQUIRED, PLEASE INDICATE:

DATE OF EXTENSION

REASON FOR EXTENSION

DATE PATIENT WAS NOTIFIED OF EXTENSION

PROCESSED BY:

SIGNATURE

PRINT NAME

DATE (DD/MM/YY)