

**REQUEST FOR MEDICAL RECORDS
(ACCESS PERSONAL HEALTH INFORMATION)**

Patient Information			
Last Name:	First Name:	Initial:	
Date of Birth (MM/DD/YYYY):	Telephone #:		
Address:			
City:	Postal Code:		

Personal Health Information Requested		
☐ Entire medical	☐ Partial medical record	Date Range/Other:
☐ Request by Patient	☐ Request by Substitute Decision Maker	
Description of Records Requested		

Patient Consent to Access/Disclosure	
Patient Name: _____ SDM Name (if applicable): _____	
I request access/copies of the medical record noted above. I authorize Mount Dennis Weston Health Centre to disclose the health information to the recipient(s) indicate above. I waive any and all claims against the Mount Dennis Weston Health Centre in connection with the disclosure or use of this personal health information once released.	
Signature:	Date:

Office Use Only: Verification of identity of individual consenting to access/disclosure	
Picture ID (requires one): ☐ HC ☐ Driver's License ☐ Passport	
Other ID (requires 2) ☐ Citizenship/birth cert ☐ Other (specify): _____	
SDM record check:	
ID checked by:	
	Printed Name Signature