

Complete the form with an **original signature** and mail to:
Health Sciences North
Health Information Services
41 Ramsey Lake Road,
Sudbury, ON P3E 5J1

Information and Instructions - EACH ACCESS REQUIRES A SEPARATE CONSENT

We will provide you with access to your personal health records, unless a legal exception applies. We will review all health record 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. For information about our privacy protection practices, contact the Chief Privacy Officer at 705-523-7100.

Last Name:	First Name:	Initial:
Mailing Address:		
Telephone #:	Alternate #: Date of	of Birth:
Hospital Medical Record #: _	RCP Medical R	ecord #:
If you are a substitute decis	sion-maker, your contact information:	
Last Name:	First Name:	Initial:
Mailing Address:		
Telephone #:	Alternate #:	
Note: Copies of documen	nts that provide your authority as substitute o	decision-maker are required.
PART B: ACCESS REQUI	EST	
_	eed and include details that will help us locate th	ne record (i.e.: dates)
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Print Name:

Signature:

Date: