Waypoint Centre for Mental Health Care
Request for Access/Copies of Personal
Health Information

Patient Name: ______________________
Place Patient Identifier Label Here
Account Number: ______________________

To: ____
(name of psychiatric facility)

I, ______________________________ ______________________________
(print full name of applicant) (address)

Request to
☐ examine my record of personal health information
☐ receive paper copies of personal health information (complete page 2)
☐ receive electronic copies (complete page 2)

The personal health information from the records of

______________________________ ______________________ ______________________
(print full name of patient) date of birth (dd/mm/yyyy) Health Card Number and Version Code

______________________________ ______________________
(signature of patient) Date (dd/mm/yyyy)

____
(if other than the patient, state relationship to the patient)
Note: If you are the patient's SDM, please include a copy of the document(s) that authorize you as the SDM

You have the right to access your personal health information unless a legal exception applies under the Personal Health Information Protection Act, 2004.

For hospital use only

Date request received by Program Manager/Director: ______________________
Date (dd/mm/yyyy)

Patient record reviewed by clinician: ☐ Yes ☐ No

Patient record reviewed by Attending Psychiatrist: ☐ Yes ☐ No

☐ access granted ☐ access granted in part ☐ access denied

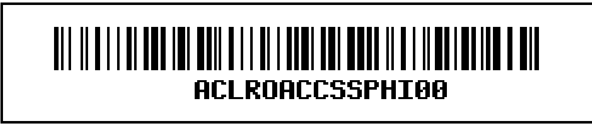
Name of Attending Psychiatrist: ______________________ ______________________
(print full name) (signature)

Date Attending Psychiatrist reviewed the file: ______________________
Date (dd/mm/yyyy)

Program Manager/Director providing authorization to Clinical Information Services to proceed with access request

______________________ ______________________ ______________________
Name of Manager/Director Signature Date (dd/mm/yyyy)

______________________ ______________________ ______________________
Received in CIS Signature Date (dd/mm/yyyy)



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To: ____
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______________________________ Health Card Number ______________________
(name of patient)

I, ____
(print full name of applicant)

hereby request photocopies of the clinical record with respect to:

Section of Clinical Record	Reports to be photocopied	Date (dd/mm/yyyy)

______________________________ ______________________________
(signature of applicant) (if other than the patient, state relationship to the patient)

Requester acknowledges receipt of copies ______________________ ______________________
(signature) Date (dd/mm/yyyy)

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