REQUEST TO ACCESS PERSONAL HEALTH INFORMATION
FROM STUDENT SUPPORT & CASE MANAGEMENT, WELLNESS & WELL-BEING, WESTERN UNIVERSITY
PURSUANT TO THE PERSONAL HEALTH INFORMATION PROTECTION ACT, (PHIPA) S.O. 2004

PATIENT DETAILS (all fields must be completed in full)	
Name:	
Date of Birth:	
Student Number:	
Phone Number:	
Mailing Address:	
Email Address:	

I authorize The Office of Student Support & Case Management, Wellness & Well-Being, Western University to release/disclose my personal health information to the following recipient: (name of person, clinic or office receiving records)

Name of Recipient:	
Address:	
Phone Number:	
Email Address:	

Patient Signature* _____ **Print Name** _____

*Patient signature or signature of *legal substitute decision maker*.

Date _____

- I understand that there is a fee for these records ($30.00 for the first 20 pages and $0.25 for each additional page) and the fee is waived if sending records directly to a clinical office.
- I understand that this authorization is valid for six months from the date of signature.
- I understand that my personal health information records cannot be released via fax.
- Information regarding the release of personal health information, this authorization form, processing time and associated fees can be found at: uwo.ca/health.
- Information regarding the release of personal health information records held within The Office of Student Support & Case Management, Western University can be found at: uwo.ca/health/case-management.
- The personal health information contained on this form is collected pursuant to the Personal Health Information Protection Act, 2004 and will be used for the purpose of responding to your request for access pursuant to section 54 of PHIPA.
- Please return this completed authorization to health@uwo.ca.