REQUEST TO ACCESS PERSONAL HEALTH INFORMATION FROM HEALTH AND WELLNESS SERVICES, 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 / Employee Number:	
Phone Number:	
Mailing Address:	
Email Address:	

I authorize Health and Wellness Services, 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:	

Please specify which personal health information records are to be released/disclosed to the above noted recipient:

☐ Entire medical record (includes psychiatry and mental health counselling records)

☐ Psychiatry records only

☐ Mental health counselling records only

☐ Other _____

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.