Kingston Health Sciences Centre
Centre des sciences de la santé de Kingston

Hôpital Hotel Dieu Hospital

KGH Hôpital Général de Kingston General Hospital

7601

We will make your personal health information and access logs available for examination unless a legal exception applies. All health record access requests will be reviewed and responded to within 30 days of receipt. Urgent circumstances may require a shorter turnaround, and this will be accommodated as is operationally possible. Fees apply for processing and photocopying; a fee schedule is available upon request. Requests involving records from eHealth Ontario or other regional/provincial systems will be redirected as appropriate. For assistance completing this form, please call **(613) 549-6666 ext. 64949**.

Request for Access to the Personal Health Record

PART A: PATIENT INFORMATION (please print)

Patient's Last Name: _____ First Name: _____ Initials:_____

Mailing Address: _____
street name/number city/town province postal code

Date of Birth (yyyy/mm/dd):_____ Health Card Number:_____

Primary Telephone Number: _____ Alternate Number: _____

PART B: DETAILS OF REQUEST

1. What records do you need? Please describe the information you want, including dates (e.g. tests, clinic notes, etc.):

_____

_____

_____

_____

2. Site(s) where you received care: ☐ Kingston General Hospital ☐ Hotel Dieu Hospital ☐ Cancer Centre ☐ Bayshore (AHF)

3. How would you like to receive your records? *(Note: Records cannot be emailed for privacy reasons)*

☐ Mail to address above **OR** ☐ Pick up (by appointment, weekdays 800-1600 at Health Information Services Kidd 1- KGH)

4. *Required Fees*: A $30 non-refundable fee that covers the first 20 pages applies. Additional pages are $0.25 per page. We will contact you to confirm total cost and delivery method before release.

PART C: AUTHORIZATION

I, _____, have the legal authority to make this request in my capacity as:
(*Print first & last name of person requesting information)*

☐ The patient

☐ Substitute Decision Maker * (attach proof of authority)

- ☐ Custodial parent/legal guardian* of an incapable youth (child under 16)
- ☐ Attorney for Personal Care of an incapable adult*
- ☐ Other: _____

☐ Estate Trustee/Executor* for a deceased patient (attach proof of authority)

**If you are not patient, provide your*: _____
(Mailing Address) *(Telephone Number)*

SIGNATURE REQUIRED: Date (yyyy/mm/dd):

Please send completed form to:
Release of Information, Kingston Health Sciences Centre
Kingston General Hospital Site
76 Stuart St, Kingston, ON K7L 2V7
Fax: 613-542-8071 Email: khscroirequest@kingstonhsc.ca

For more information scan the QR code or visit "My Health Care Information" at www.kingstonhsc.ca