Ontario Health
Digital Services

Electronic Health Record Request for Access and Correction Form

Overview

This form is to be used to request access and correction to personal health information (PHI) in the electronic health record (EHR). You can make a request if you are the individual to whom the record relates or if you are the individual's substitute decision maker authorized under the *Personal Health Information Protection Act*, *2004.*

Instructions

1. Complete the required (*) fields.
2. Mail or fax the completed form with supporting documentation to:
    a. Mail:

        Privacy Office
        Ontario Health - Digital Services
        777 Bay Street, 7th Floor
        PO Box 148
        Toronto, ON M5G 2C8

    b. Fax: 416-586-4397 or 1-866-831-0107

Please do not use email to submit this form. Requests submitted via email will be declined and deleted, and the individual will be asked to resubmit the request by mail or fax.

Questions

Questions about this form and how to complete it should be directed to the Privacy Office of the Digital Services business unit of Ontario Health as follows:

- **Phone:** 416-946-4767 or 1-888-411-7742, Ext. 64767
- **Email:** OH-DS_privacy@ontariohealth.ca

Note: Please do not include any personal health information in your email (i.e. health card number or medical history).

- **Mail:**

  Privacy Office
  Ontario Health - Digital Services
  777 Bay Street, 7th Floor
  PO Box 148
  Toronto, ON M5G 2C8

- **Fax:** 416-586-4397 or 1-866-831-0107

Further information is also available on our website:
https://www.ehealthontario.on.ca/en/privacy/managing-access-to-your-ehr

PLEASE COMPLETE THE REQUIRED (*) FIELDS

TYPE OF REQUEST (select one):

☐ ACCESS/CORRECTION REQUEST FOR MY OWN PERSONAL HEALTH INFORMATION

☐ ACCESS/CORRECTION REQUEST BY AN AUTHORIZED PERSON DESIGNATED TO CONSENT ON BEHALF OF ANOTHER INDIVIDUAL

☐ ACCESS/CORRECTION REQUEST BY AN AUTHORIZED(LEGAL) REPRESENTATIVE ON BEHALF OF A CLIENT REGARDING THEIR INDIVIDUAL'S PERSONAL HEALTH INFORMATION

SECTION 1: REQUESTER'S INFORMATION

(TO BE COMPLETED BY PERSON MAKING THE REQUEST)

*FIRST NAME	*LAST NAME	*Title:

*MAILING ADDRESS:

STREET NO.	STREET NAME	UNIT NO.

CITY	PROVINCE	POSTAL CODE

*PLEASE INDICATE YOUR PREFERRED METHOD OF COMMUNICATION:

☐ MAIL ☐ TELEPHONE ☐ EMAIL	PHONE NUMBER (DAYTIME)	PERMISSION TO LEAVE VOICEMAIL ☐ YES ☐ NO

EMAIL ADDRESS

SECTION 2: INDIVIDUAL WHOSE PHI IS BEING REQUESTED (FOR ACCESS AND/OR CORRECTION)

*FIRST NAME:	* LAST NAME:	*Date of Birth: MM/DD/YYYY

*PROVIDE ONE OF THE FOLLOWING:

☐ ONTARIO HEALTH CARD NUMBER:

☐ MEDICAL RECORD NUMBER & NAME OF ORGANIZATION THAT ISSUED THE MEDICAL RECORD NUMBER:

☐ CLIENT HEALTH AND RELATED INFORMATION SYSTEM (CHRIS) CLIENT NUMBER:

*MAILING ADDRESS:

STREET NO.	STREET NAME	UNIT NO.

CITY	PROVINCE	POSTAL CODE

If you are submitting this request as a substitute decision-maker, you must also submit one photocopy of a document that shows you are entitled to act as the substitute decision-maker for the individual identified in Section 2. For example, a legal document demonstrating you have sole custody or guardianship. Please visit our website for further information regarding the types of documentation that may be submitted as proof of authority.

SECTION 3: ACCESS REQUESTED

☐ **Acute and Community Care Clinical Data Repository (acCDR)** includes: clinical reports, discharge summaries, emergency department and visits and encounters	Personal health information contained in acCDR between the time periods specified below: From MM/DD/YYYY To MM/DD/YYYY (2014 onwards)
☐ **Diagnostic Imaging Common Services Repository (DI CS)** includes: diagnostic imaging reports **Note:** Please contact your health care provider for a copy of diagnostic images.	Personal health information contained in DI CS between the time periods specified below: From MM/DD/YYYY To MM/DD/YYYY (2014 onwards)

SECTION 4: CORRECTION REQUESTED (SKIP IF REQUEST IS RELATED TO ACCESS ONLY)

Personal Health Information Protection Act, 2004 requires that correction requests be made based on records that were received thorugh an access request. Please identify the name of the Health Information Custodian that created the record, provided access and time period related to the records.

☐ **Acute and Community Care Clinical Data Repository (acCDR)** includes: clinical reports, discharge summaries, emergency department and visits and encounters.	**Name of Health Information Custodian:** From MM/DD/YYYY To MM/DD/YYYY (2014 onwards) **OR** Date of visit**:** MM/DD/YYYY
☐ **Diagnostic Imaging Common Services Repository (DI CS)** includes: diagnostic imaging reports	**Name of Health Information Custodian:** From MM/DD/YYYY To MM/DD/YYYY (2014 onwards) **OR** Date of visit: MM/DD/YYYY

SECTION 5: ONTARIO HEALTH IS NOT AUTHORIZED TO FACILITATE ACCESS AND CORRECTION REQUESTS RELATED TO THE CLINICAL DATA LISTED BELOW. ACCORDINGLY, PLEASE CONTACT THE APPROPRIATE CONTACT PROVIDED BELOW.

Primary Care Clinical Data Repository (pcCDR) includes: clinical information from primary care providers (such as a general practitioner or family physician) submitted via certified electronic medical record systems	For Access and Correction requests, please contact **ClinicalConnect Program Office, Telephone: (905) 577-8270 ext. 9, Email: privacy@clinicalconnect.ca**

Ontario Laboratories Information System (OLIS) includes: laboratory test orders and results (urine, blood, microbiology)	For Access and Correction requests, please contact **Freedom of Information & Privacy Coordinator, Access and Privacy Office, Ministry of Health, 99 Adesso Drive, 1st floor Concord, ON, L4K 3C7** **Telephone: 416-327-7040, Email: generalapo@ontario.ca**
Drug and Pharmacy Services (DHDR) includes: publicly funded drugs and pharmacy services as well as monitored drugs	For Access requests, please contact **Service Ontario INFOline, Telephone: 1-800-291-1405 TTY 1-800-387-5559** For Correction requests, please contact **Drug Programs Delivery Branch, Ontario Public Drugs Program Division 5700 Yonge Street 3rd Floor Toronto, ON M2M 4K5** **The written request should include at a minimum:** • Name and address, phone number • Date of birth • Health card number • Signature What information needs to be corrected and the specific date range required to be corrected.

SECTION 6: AUTHORITY TO MAKE THE REQUEST

I,

_____
(Last Name, First Name of person providing authorization for access/correction)

have the legal authority to make this request as I am (please select **one** of the following options):

☐ the individual identified in **Section 2:**

☐ the individual's parent or other person lawfully entitled to make an access request for a child who is under the age of 16. You are NOT entitled to make an access request for a child's personal health information on behalf of the child if it relates to treatment provided to the child that the child consented to on their own or if the child is capable and disagrees with you accessing their personal claims history.

☐ the Substitute Decision Maker for the individual identified in **Section 2**, who does not have capacity.
Please indicate your relationship to the individual. See list of authorized Substitute Decision Makers included in the instructions to this form (page 5).

☐ the individual's estate trustee or individual who has assumed responsibility for the administration of the individual's estate.

☐ I understand that making a false assertion is an offence under the Personal Health Information Protection Act, 2004.
SECTION 7: IDENTIFICATION FOR REQUESTS MADE BY SUBSTITUTE DECISION MAKER
Describe the type of document you will be providing – (Refer to Pages 7-8) E.g. Legal Document of Guardianship
SECTION 8: SIGNATURE OF REQUESTER OR LEGAL REPRESENTATIVE

NAME (PRINT):	DATE: MM/DD/YYYY
SIGNATURE: ☐ As legal representative, I have confirmed the identity of my client (the subject of this request) and have provided an authorization from my client	
INSTITUTION USE ONLY	
Form Completed: ☐ Yes ☐ No	Date Received: : MM/DD/YYYY
Identity Verfied: ☐ Yes ☐ No	Privacy Ticket #
Notes:	

ADDITIONAL INSTRUCTIONS FOR A SUBSTITUTE DECISION MAKER

What does "substitute decision maker" mean and who is authorized under the *Personal Health Information Protection Act*, *2004* to act as the individual's "substitute decision maker"?

A substitute decision maker is someone who is authorized under the *Personal Health Information Protection Act*, *2004* to consent on behalf of an individual to the collection, use or disclosure of personal health information about the individual.

Substitute decision makers can make requests for personal health information on behalf of individuals who do not have capacity to make such requests. You can act as a substitute decision maker for a person who does not have capacity to make their own request if you have capacity **and** you are the highest ranked person on the list below:

- a substitute decision maker within the meaning of the *Health Care Consent Act*, if the collection, use or disclosure of information is connected to the decision of a substitute decision maker about the individual's treatment;
- the guardian of the person or guardian of property;
- the attorney for personal care or attorney for property;
- the representative appointed by the Consent and Capacity Board;
- the spouse or partner;
- a child, a parent, a Children's Aid Society or other person who is allowed by law to give or refuse consent in the place of the parent;
- a parent who has a right of access to the child;
- a sibling;
- a relative; or
- the Public Guardian and Trustee, if no other person meets the requirements.

How does a health information custodian determine whether a person is the substitute decision maker for the deceased individual?

When an individual dies, the estate trustee or the person who has assumed responsibility for the administration of the deceased's estate becomes the substitute decision maker for the deceased individual.

Who can submit a request for a child under 16 years of age?

1. **The child**
2. **A parent of the child** (including a child with capacity), a member of a Children's Aid Society, or another person who is legally able to request personal health information in the place of the parent **with the exception of the situations noted below**:

- A child under the age of 16 who consented to their own treatment must decide whether to consent to the collection, use or disclosure of their personal health information related to that treatment.

- If a child under the age of 16 has capacity to make a request and disagrees with the decision of their parent (or the person legally able to make the request in place of the parent), the child's decision overrides the decision of their parent (or the person legally able to make the request in place of the parent).

Note: There are two situations in which the parent (or other legally authorized person) cannot make this request:

- If the personal health information relates to a treatment that a child consented to (or refused to consent); or
- If the child is capable of consenting and makes a decision about their personal health information that conflicts with the parent, or other legally authorized person's decision.

Acceptable identity documents

If the request is related to another individual's health information, you must include **one** photocopy of a document from the list below:

Person is 11 years or younger	Birth certificate for the individual Identification of both parents from a federal, territorial, provincial, municipal, or state authority Signatures from both parents appearing in the birth certificate of the patient.
	A legal document demonstrating that the substitute decision maker has sole custody or guardianship for the patient.
	Letter from a health care organization that confirms the substitute decision maker has the authority to view the health information of the individual.

Person is 12 to 15 years old	Signed letter from the individual indicating the substitute decision maker has the authority to view his or her health information. Student card or identification from a federal, territorial, provincial, municipal or state authority for the individual.
	Letter from a healthcare organization that confirms the substitute decision maker has the authority to view the health information of the individual.

Person is 16 years or older	Signed letter from the individual indicating the substitute decision maker has the authority to view his or her health information Identification from a federal, territorial, provincial, municipal or state authority for the individual.
	A legal document demonstrating that the substitute decision maker has sole custody or guardianship for the individual.
	Letter from a health care organization that confirms the substitute decision maker has the authority to view the health information of the individual.