

Your Information:

<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Miss First Name: _____ Address: (Street/Apt. P.O. Box/R.R. No.) _____ Province: _____ Telephone Number (Day): _____	Last Name: _____ Middle Name: _____ City/Town: _____ Postal Code: _____ Telephone Number (Evening): _____
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Substitute Decision-Maker Information: *

<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Miss First Name: _____ Address: (Street/Apt. P.O. Box/R.R. No.) _____ Province: _____ Telephone: _____	Last Name: _____ Middle Name: _____ City/Town: _____ Postal Code: _____ Email: _____
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**Please provide documentation to satisfy the health information custodian that you are an authorized substitute decision-maker, if available.*

Please provide a detailed description of the personal health information you are requesting in order to assist in identifying and locating the appropriate record(s).

Preferred method of access to records:	<input type="checkbox"/> Examine Original <input type="checkbox"/> Receive Copy	Signature: _____	Date: _____
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For Health Information Custodian Use Only

Date Received: _____	Request Number: _____	Comments: _____
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