Electronic Health Record (EHR)
Access and Correction Request for Service Form - ConnectingGTA

INSTRUCTIONS TO THE PERSON MAKING THE REQUEST:

- Please complete this form with as much information as possible. Fields indicated with an asterisk (*) are mandatory fields. This will help eHealth Ontario fulfill your request.
- eHealth Ontario only accepts requests from the patient or someone authorized to make the request for the patient (i.e., substitute decision maker). You will need to:
  - Provide proof of your identity (please see attached instructions for valid forms of identification)
  - If you are not the patient, prove that the patient has allowed you to view his or her information (please see attached instructions for valid forms of identification)
- Ontario's privacy law, *Personal Health Information Protection Act, 2004 (PHIPA)* allows a health care organization to charge administrative fees to an individual who wants a copy of his or her records. If the organizations that put your information in the electronic health record charge a fee, we will ask you to pay before fulfilling your request.
- Mail or fax the completed form to:
  - Mail: eHealth Ontario Privacy Office, P.O. Box 148, 777 Bay Street, Suite 701, Toronto, Ontario, M5G 2C8
  - Fax: (416) 586-4397 or 1 (866) 831-0107
- Please do not use email to submit this form.
- If you have questions about this form, contact the eHealth Ontario Privacy Office at 416-946-4767 or email contact Privacy@ehealthontario.on.ca with your name and phone number.

Type of Request:		
☐ Access Request	☐ Correction Request	
REQUESTOR'S CONTACT INFORMATION		
(To be completed by person making the request)[1]		
*First name:	*Last name:	
*Mailing address:	*Title:	
*City:	*Province:	*Postal code:
*Preferred phone (daytime):		
Relationship: ☐ Patient ☐ Substitute decision maker:		
Preferred method of contact: ☐ Mail ☐ Telephone	Permission to leave voicemail ☐ Yes ☐ No	
PATIENT INFORMATION		
*First name:	*Last name:	
*Gender: ☐ Male ☐ Female	*Date of birth: MM/DD/YYYY	
*Health card number/**Medical record number:		
*Name of hospital/clinic that issued the medical record number:		
*Mailing address:	*Preferred phone (day time):	
*City	*Province:	*Postal Code:

[1] If a HIC is making the request please leave the *Requestor's Contact Information* section blank and complete the *HICs Only* section on page 3.
**Medical record number is only required if the health card number is not available.

Ontario
eHealth Ontario

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Access and Correction Request for Service Form - ConnectingGTA

TYPE OF REQUEST (check all that apply)	
ACCESS REQUEST:	
☐	All health information about you in the ConnectingGTA (cGTA)
☐	Some health information about you in the cGTA (complete relevant information below). Information put in by the following health care organizations:_____ Information entered in the last: ☐ Three months ☐ 12 months ☐ Five years ☐ Six months ☐ Three years ☐ All information Type of information: ☐ Hospital notes (e.g., doctor's assessment of you while in hospital) ☐ Community notes (e.g., doctor's assessment of you while at a clinic outside the hospital) ☐ Diagnostic images (e.g., X-Ray, ultrasound) ☐ Labs and pathology (e.g., blood test, tissue sample) ☐ Other results (e.g., ECG, neurological reports) ☐ Allergies ☐ Medications
☐	List of all people that have viewed information about you in the cGTA, or
☐	List of some people that have viewed information about you in the cGTA (complete relevant information below). A certain person (provide name and where s/he works):_____ Everyone from the following organizations:_____ People who viewed my record in the past: ☐ 3 months ☐ 12 months ☐ 5 years ☐ 6 months ☐ 3 years ☐ All records
☐	List of consent instructions that you have provided for the cGTA and changes you have made to them.
☐	List of all times when someone has overridden your consent instructions in the cGTA, or
☐	List of some times when someone has overriden your consent instructions in the cGTA (complete relevant information below). Done by a certain person (provide name and where s/he works):_____ Everyone from the following organizations:_____

Only overrides in the past:

☐ 3 months ☐ 12 months ☐ 5 years
☐ 6 months ☐ 3 years ☐ All overides

Specify time range for this request (if applicable): Start date: MM/DD/YYYY End date: MM/DD/YYYY

CORRECTION REQUEST (Indicate details of corrections below):

Describe the information that you feel is not correct or out-of-date, and the suggested correction. provide as much detail as possible

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IDENTIFICATION

Please include a photocopy of:

- Your identification
- If you are asking for health information about someone else, proof that he or she has allowed you to see the information

Please see the identification requirements at the end of this form for acceptable forms of ID and documentation.

SIGNATURE

Name (print) :	Date: MM/DD/YYYY
Signature:	*Before sending this form to eHealth Ontario, make sure you have included:* ☐ *Completed form* ☐ *Photocopy of identification* ☐ *If you are asking for someone else, proof that you have permission from the patient.*

FOR HEALTH CARE CUSTODIANS (HICS) ONLY

*Facility name:	*Site/hospital name:	
*Patient medical record number:	*Requestor's job title:	
*First name:	*Last name:	
*Title:	*Business phone (include ext.):	*Business email:
Special instructions:		

FOR eHEALTH ONTARIO OFFICE USE ONLY

Form Completed: ☐ Yes ☐ No	Remedy Ticket #
Identity Verfied: ☐ Yes ☐ No	
Notes:	

FOR UHN USE ONLY

☐ Logs produced and delivered to eHealth Ontario	Date: MM/DD/YYYY

IDENTIFICATION REQUIREMENTS

Identification Requirements
Please include photocopies of the relevant document(s) below to confirm your identity and your authority to view the health information if you are asking for health information that is not yours.

If you have trouble obtaining the documents, you may also ask your health care provider to contact eHealth Ontario to confirm your identity and authority.

1. If you are asking for health information about yourself, you must include a photocopy of one of the documents from list A:

2. If you are asking for health information about another person, you must include a photocopy of one document from list A and one photocopy of a document from list B:

LIST A: Proof of Identity	LIST B: Proof of Authority	
	Patient Is:	One of the following sets of documentations
• Identification from a federal, provincial, municipal or state authority • Student card (if 18 years or younger) • Letter from a health care organization that confirms the requestor's identity (i.e., that the individual is who they say that they are)	11 years or younger	• Birth certificate for the individual • Identification for both parents from a federal, territorial provincial, municipal, or state authority • Signatures from both parents appearing in the birth certificate
		• A legal document demonstrating that the individual has sole custody or guardianship for the patient
		• Letter from a health care organization that confirms the requestor's has the authority to view the health information
	Individual is 12 to 18 years old	• Signed letter from the individual indicating the requestor 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
		• A legal document demonstrating that the Requestor has sole custody or guardianship for the individual
		• Letter from a healthcare organization that confirms the Requestor's has the authority to view the health information
	Individual is 19 years or older	• Signed letter from the individual indicating the requestor 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 requestor has sole custody or guardianship for the individual
		• Letter from a health care organization that confirms the requestor's has the authority to view the health information

Examples of Documents

Document	*Example*
Identification from a federal, territorial provincial, municipal, or state authority	*Driver's license, passport, citizenship card, certificate of Indian status, Ontario photo card*
Student Card	*Howard Park Public School, St. Vincent Academy, Parkdale Collegiate*
Letter from a health care organization in Ontario	*Letter from Mount Sinai Hospital saying that you are Jane Doe or that you are Jane Doe and have authority to view Janet Yan's health information*