Barrie and Community Family Health Team

370 Bayview Drive, Third Floor, Barrie ON L4N 7L3 Ph: 705-721-0370 Fax: 705-725-4708 www.Barriefht.ca

Access to Personal Health Records Request Form

Barrie and Community Family Health Team
&
Barrie Family Health Organization
&
Barrie and Community Family Medicine Clinics
(The *Health Circle*)

Process Outline

All patients have the right to access and correct their own personal health information that is collected by any healthcare provider. The *Health Circle* is a healthcare provider and health information custodian, the BCFHT can assist you in accessing your personal health records. Only copies of the records can be provided, originals are required by law to be held by the members of the *Health Circle*.

Once the required information below is completed and the form has been received by the *Health Circle*, the *Health Circle* and its members have 30 days to complete the request. If the *Health Circle* is unable to complete the request in full within the initial 30 days, the members of the *Health Circle* will inform the patient and notify them of the expected delivery date.

Please complete the required information below and provide back to the Health Circle by one of the following ways:
- Hand deliver or mail back to the provider that provided you this documents;
- Hand deliver or mail to the *Health Circle* Privacy Team at **370 Bayview Dr. 3rd Floor, Barrie ON, L4N 7L3**; or
- Email to the *Health Circle* Privacy Team at **accessprivacy@bcfht.ca** (but please be aware that there is a higher level of risk associated with sending requests via email).

If you have any questions, please contact Sean McConnachie, Associate Privacy Officer, at accessprivacy@bcfht.ca or 705-721-0370 x 2135.

PATIENT INFORMATION (please print)

Last Name: _____ **First Name:** _____ **Initials:** _____

Date of Birth: _____
(yyyy/mm/dd)

Mailing Address: _____

Telephone #: _____ **Alternate #:** _____

IF YOU ARE MAKING THE REQUEST AS A SUBSTITUTE DECISION-MAKER (SDM), WE REQUIRE THE FOLLOWING INFORMATION ABOUT YOU: (please print)

Last Name: _____ First Name: _____ Initials: _____

Mailing Address: _____

Telephone #: _____ Alternate #: _____

Relationship to Patient: _____

INFORMATION REQUESTED

Please indicate below the information you would like to receive:

- ❑ Complete health record (everything)
- ❑ Specific visit: (enter date) _____
- ❑ Specific range of dates: from _____ to _____
- ❑ Specific condition or health issue: _____
- ❑ Other (Please provide as much detail as possible) _____

_____

_____

_____

DELIVER OF REQUESTED INFORMATION

Please indicate below how and to where you would like the information to be provided to you.

PATIENT ACKNOWLEDGMENT

I understand that upon receipt of my personal health information I am responsible for the protection of this information and indemnify the BCFHT of any loss or exposure of the information that has been transferred to me. The BCFHT will continue to meet its privacy requirements and obligations for the personal health information that it has within its custodianship. Any requests for changes to your medical record will have to be discussed with your primary health provider prior to changes being made.

_____	_____	_____
(Name of Patient or SDM)	**(Signature)**	**(Date: yyyy/mm/dd)**
_____	_____	_____
(Name of Witness)	**(Signature)**	**(Date: yyyy/mm/dd)**