Cornwall Community Hospital
Hôpital communautaire de Cornwall

Cornwall Community Hospital Access to Personal Health Record

Information and Instructions

You will be provided with access to your personal health record, unless a legal exception applies. The hospital will review all health record access requests, and will make every effort to respond to your request in a timely fashion. Please complete Parts A and B of this Form. Part C is for our internal use. For information about our privacy protection practices call 938-4240 ext. 4700.

PART A: REQUESTOR INFORMATION

Patient Contact Information:

Last Name	First Name	Initials
Mailing Address		
Telephone Number	Date of Birth	Hospital ID Number

If you are a substitute decision-maker, your contact information:

Last Name	First Name	Initials
Mailing Address		
Telephone Number		

Note: Include copies of documents that provide your authority as a substitute decision-maker.

PART B: ACCESS REQUEST

1. Please describe what you need and include details that will help us locate the record (e.g., dates, name of healthcare provider, etc.).

_____

_____

2. How would you prefer to access this information? Please check off:

☐ Receive hard copies of originals

☐ Examine originals in the facility

_____ _____ _____

Signature Name (print) Date

This form is also available in French under the title:
« Accès aux dossiers de renseignements personnels sur la santé à l'Hôpital communautaire de Cornwall »

Cornwall Community Hospital
Hôpital communautaire de Cornwall

Cornwall Community Hospital Access to Personal Health Record

PART C: RESPONSE TO ACCESS REQUEST (For Internal Use Only)

1. Information Regarding Receipt and Initial Review of Request

_____
Date Request Received

2. Information Regarding Response

_____
Date Response Issued

☐ Access request granted
☐ Access request not granted
☐ Access request granted in part

If complete access request was not granted, reason for refusing the request/part of the request.

_____

3. **Information Regarding Extension**

If an extension to the access request response was required, please indicate:

Date of Extension	Reason for Extension	Date Patient Notified

4. Processed by:

_____ _____ _____
Signature Name (print) Title