5310 Explorer Drive
Mississauga, Ontario L4W 5H8

1.800.251.6543
647.428.2005 **tel**
647.428.2006 **fax**

Personal health information request form

To request personal health information:

- Complete this form *in full*
- Write a cheque for $30.00 payable to Ornge (for more information about fees please visit our Privacy and Information webpage.
- If you are acting on behalf of the patient, include any documents necessary to prove that you have the power to do so, e.g. power of attorney, will, etc.
- Mail all of the above to the address above and mark your letter "**ATTN: HEALTH RECORDS**"

If you have any questions about your request, please contact healthrecords@ornge.ca.

PATIENT'S INFORMATION *(please print clearly)*:

Last Name		First Name		Date of Birth (dd-mm-yyyy)
Unit Number	Street Number	Street Name/ P.O Box		
City/Town		Province	Country	Postal Code/ Zip Code
Telephone Number ( ) - ext.		Email		

REQUEST FOR:

Date of Ornge Transfer (dd-mm-yyyy):	
Description of the personal health information requested:	Location - if Ornge attended **at the scene** of an accident/incident:
Interfacility Transfer Sending Hospital: Sending City:	Receiving Hospital: Receiving City:

PATIENT'S SIGNATURE: **DATE (dd-mm-yyyy):**

_____ _____

This form must contain the original signature of the patient. Please note, it is a punishable offence under the *Personal Health Information Protection Act, 2004* to request personal health information under false pretences.

Personal Information contained on this form is collected pursuant to the *Personal Health Information Protection Act, 2004* and will be used to respond to your request. By submitting this form you are consenting to receive correspondence from Ornge via the provided contact information. Any questions about this should be directed to the Information and Privacy Office at 647.428.2005. (Version 2014-07-14)

SUBSTITUTE DECISION MAKER/LEGAL REPRESENTATIVE (if applicable)

If you are the substitute decision maker or legal representative requesting information on behalf of a patient, please provide the following information and copies of documents that provide your authority to act on behalf of the patient, e.g. power of attorney for personal care, will, etc.

Last Name		First Name		Relationship to Patient
Unit Number	Street Number	Street Name/ P.O Box		
City/Town		Province	Country	Postal Code/ Zip Code
Telephone Number ( ) - ext.		Email		

SUBSTITUTE DECISION MAKER/LEGAL REPRESENTATIVE'S SIGNATURE: DATE (dd-mm-yyyy):

_____ _____

This form must contain the original signature of the patient. Please note, it is a punishable offence under the *Personal Health Information Protection Act, 2004* to request personal health information under false pretences.

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