BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT
www.healthunit.com

REQUEST FOR ACCESS OR DISCLOSURE OF PERSONAL HEALTH INFORMATION

Instructions

Submit this form, along with a copy of government-issued photo identification, to:

Middlesex-London Health Unit, 355 Wellington Street, Suite 110, London, ON, N6A 3N7
Attention: Privacy Officer

If you have any questions or need assistance completing this form, please call (519) 663-5317, ext. 2437 or email privacy@mlhu.on.ca.

Request Details

I am requesting access/disclosure of the following information:

Concerning: _____ Date of Birth: _____
Name of Client (YYYY/MM/DD)

Person/Agency to Receive Information

☐ Client or Person (With Legal Signing Authority) Consenting to Access/Disclosure

☐ Other – Specify:

Name:

Address:

Telephone: Email:

Client or Person (With Legal Decision Making Authority) Consenting to Access/Disclosure

Name:

Address:

Telephone: Email:

Relationship (if consenting on behalf of client):

_____ _____
Signature of Client/Substitute Decision Maker Date (YYYY/MM/DD)

Office Use Only – Verification of Identity of Individual Consenting to Access/Disclosure

Form of ID: ☐ Driver's License ☐ Passport ☐ Notarized Letter/Lawyer's Letter ☐ Other: _____

ID Checked By: _____ _____
Printed Name Signature