Ontario Health
Digital Services

Electronic Health Record (EHR)
Access and Correction Request for Service Form
ConnectingOntario (cON)

INSTRUCTIONS

- Complete this form with as much information as possible. Fields indicated with an asterisk (*) are mandatory fields.
- Ontario Health 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 (see page 4 for attached instructions of valid forms of identification)
  - Provide proof that the patient has allowed you to view his/her information if you are a substitute decision maker (see page 4 for attached instructions for valid forms of identification)

Please note:

- The organization(s) that placed your information in the electronic health record **will be informed** of your Request for Access.
- Contributions by organizations to ConnectingOntario commenced **July 1, 2014**. Should you require medical information prior to this date, please contact the organization directly.
- Ontario's privacy law, *Personal Health Information Protection Act, 2004 (PHIPA),* allows a healthcare organization to charge administrative fees to an individual who requests a copy of his/her records. If the organizations that placed your information in ConnectingOntario charge a fee, Ontario Health will notify you of next steps to have your request fulfilled.
- Mail your completed form to:
  Ontario Health (Digital Services) Privacy Office
  777 Bay Street
  Suite 701
  P.O. Box 148
  Toronto, Ontario
  M5G 2C8
- Questions may be directed to Ontario Health Digital Services Privacy Office at: (416) 946-4767 or 1 (888) 411-7742 x 64767.

Type of Request:	
☐ **Access Request**	☐ **Correction Request**

REQUESTOR'S CONTACT INFORMATION		
(To be completed by person making the request)		
*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:

¥ Medical record number is only required if the health card number is not available.

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TYPE OF REQUEST (check all that apply)	
ACCESS REQUEST:	
☐	**All** health information about you in **ConnectingOntario (cON)**
☐	**Some** health information about you in **cON** (complete relevant information below). Information put in by the following healthcare organizations:_____ Information entered in the last: ☐ 3 months ☐ 2 years ☐ 6 months ☐ 3 years ☐ 12 months ☐ 5 years Type of information: ☐ Hospital documents/notes (e.g., doctor's assessment of you while in hospital) ☐ Diagnostic imaging reports (e.g., X-Ray reports, ultrasound reports) ☐ Community notes (e.g., assessment of you while at a clinic outside the hospital)
☐	List of **all** people that have viewed information about you in **cON**, or
☐	List of **some** people that have viewed information about you in **cON** (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 ☐ 2 years ☐ 6 months ☐ 3 years ☐ 12 months ☐ 5 years
☐	List of consent instructions that you have provided for **cON** and changes you have made to them.
☐	List of **all** times when someone has overridden your consent instructions in **cON**, or
☐	List of **some** times when someone has overriden your consent instructions in **cON** (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 ☐ 2 years
☐ 6 months ☐ 3 years
☐ 12 months ☐ 5 years

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/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 Ontario Health, 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.*

IDENTIFICATION REQUIREMENTS

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.

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

LIST A: Proof of Identity

Proof of Identity	• 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)

LIST B: Proof of Authority

Patient's Age	Provide one of the following sets of documents
11 years of age or younger	• Birth certificate for the patient • Identification for both parents of the patient from a federal, territorial provincial, municipal, or state authority • Signatures from both parents of the patient appearing in the birth certificate
	• A legal document demonstrating that the requestor has sole custody or guardianship of the patient
	• Letter from a healthcare organization that confirms the requestor has the authority to view the patient's health information
12 to 18 years of age	• Signed letter from the patient indicating the requestor has the authority to view his/her health information • Student card or identification from a federal, territorial provincial, municipal or state authority for the patient
	• A legal document demonstrating that the requestor has sole custody or guardianship of the patient
	• Letter from a healthcare organization that confirms the requestor has the authority to view the patient's health information
19 years of age or older	• Signed letter from the patient indicating the requestor has the authority to view his/her health information • Identification from a federal, territorial provincial, municipal or state authority for the patient
	• A legal document demonstrating that the requestor has sole custody or guardianship of the patient
	• Letter from a healthcare organization that confirms the requestor has the authority to view the patient's health information

Examples

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