

FREEDOM OF INFORMATION REQUEST FORM

Under the *Freedom of Information and Protection and Privacy Act*

Instructions and Payment

A \$5 application fee is required. Please make cheques or money orders payable to the Espanola Regional Hospital & Health Centre and either mail or drop off the completed form to the Health Records Department.

Requestor's Information (please print)

First Name Last Name Organization (if applicable)

Mailing Address

Telephone

Email (optional, records will not be sent by email)

Request

Description of Records (please provide as much detail as possible)

Time period of records

From: (YYYY-MM-DD)

To: (YYYY-MM-DD)

Signature

Date
