UPPER GRAND DISTRICT SCHOOL BOARD

# Request to Access Personal Health Information

under the Personal Health Information Protection Act, 2004

**Student Information:**

Legal Name when record was created: _____ Given Name(s):_____

Please list any other Names used:

_____

Address: _____ Unit: _____ City: _____

Province: _____ Postal Code: _____ Telephone: _____ E-mail: _____

**Parent/Guardian/Substitute Decision-Maker Information (for an incapable student):**

Surname: _____ Given Name(s): _____

Address: _____ Unit: _____ City: _____

Province: _____ Postal Code: _____ Telephone: _____ E-mail: _____

---

Please check the boxes of the personal health information you are requesting and write in the details that will assist in locating this information (e.g., dates, name of health care provider, etc.)

- ☐ Assessment/Report
  - ☐ Psychological/Psychoeducational Services
  - ☐ Behaviour Analyst Services
  - ☐ Speech-Language Pathology Services
- ☐ Other Services
  - ☐ Child and Youth Counsellor Services
  - ☐ Social Work Services

Please provide additional details pertaining to your request (if applicable):

| |
|---|
| |

**NOTE**: *Authorization must be signed by the capable student, unless the request is from a parent/guardian of a student under the age of 18 to access a Psychological or Speech and Language Assessment Report under the authority of the Education Act. If the student is deemed incapable of consenting to the disclosure of their personal health information, a parent/guardian may consent. The personal health information contained on this form is collected pursuant to the Personal Health Information Act, 2004 (“the Act”) and will be used for the purpose of responding to your request for access pursuant to Section 54 of the Act. Questions about this collection should be directed to the appropriate Manager of Student Support Services or Mental Health Lead.

---

UPPER GRAND DISTRICT SCHOOL BOARD

# Request to Access Personal Health Information

under the Personal Health Information Protection Act, 2004

**Indicate preferred method of record distribution.**

☐ **In-Person pick up**

Government issued photo identification required

- By applicant
- By Other (authorized release) to

_____

*(indicate full name)*

_____

*Signature of above authorized individual receiving record in person*

☐ **Postal Service/Courier**

Mailing address for:

☐ Student

☐ Parent/Guardian/Substitute Decision Maker

☐ **Email Address:** _____

*by checking this box you acknowledge the risks of email communication, and consent to its use:*
The security of email messages is not guaranteed. Messages sent to, or from, your provider may be seen by others who have access to your device or your accounts. E-mail is easy to forge, may be accidentally forwarded, and may exist indefinitely. It is recommended that you do not use email to discuss or share health information you feel is sensitive.

**APPLICANT'S SIGNATURE:** _____ **DATE**: _____

**Please send all completed requests to** healthrecordrequest@ugdsb.on.ca

---

FOR STAFF USE ONLY

☐ Identification Reviewed

☐ Record Picked Up/ Emailed/ Mailed

☐ Documentation of request made in student record

Staff Signature: _____

Date: _____

**A copy of this request must be placed or uploaded into the student's clinical file.**

Revised March 2024