yukon hospital corporation

Application for Access to Personal Health Information

About You			
Last Name		First Name	
Mailing Address	City/Town	Territory/Province	Postal Code
Date of Birth (yyyy/mm/dd)			
Contact Number (Daytime)		Contact Number (Evening)	
Email Address (Optional)			

About your request
Do you want to: (a) receive a copy of the records ☐ **OR** (b) examine the record ☐

About the information you want to access
What records do you want to access? Please give as much detail as possible. If you need more space, please attach a separate sheet of paper.
What is the time period of the records? Please give specific dates.

Your signature	Signature	Date

For authorized office use only

Date received	Reference # ____________ ☐ Identification verified ☐ Fee estimate provided Response Deadline: ____________ Date Activated: ____________