



Freedom of Information Office
 The Credit Valley Hospital and Trillium Health Centre
 Clinical and Administration Building, 4th Floor
 100 Queensway West
 Mississauga, ON L5B 1B8

Freedom of Information Request Form (page 1 of 2)

This request should be submitted to The Credit Valley Hospital and Trillium Health Centre’s Freedom of Information Office. Please note that a \$5.00 application fee is required for all requests (cheque made payable to “The Credit Valley Hospital and Trillium Health Centre”, or complete the credit card information on the reverse of this sheet).

Request For: Access to General Records Access to Own Personal Information Correction to Own Personal Information

Mr. Mrs. Ms. Miss Last Name: _____

First Name: _____ Middle Name: _____

Address: (Street/Apt. No./P.O. Box/R.R. No.) City/Town: _____

_____ Postal Code: _____

_____ Telephone (Day): () _____

Province: _____ Telephone (Evening): () _____

Provide a detailed description of requested records, personal information, or personal information to be corrected. If you are requesting general records, please provide the date periods of the records you wish to access (e.g., records from 2007-2009). If you are requesting access to, or correction of, your personal information, please identify the personal information bank or record containing the personal information, if known.

Please note: if you are requesting a correction of personal information, please indicate the desired correction, and if appropriate, attach any supporting documentation. You will be notified if the correction is not made and you may require that a statement of disagreement be attached to your personal information.

Personal Information contained on this form is collected pursuant to the *Freedom of Information and Protection of Privacy Act* and will be used for the purpose of responding to your request. Questions about this collection should be directed to the Information and Privacy Coordinator at The Credit Valley Hospital and Trillium Health Centre.



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Freedom of Information Request Form (page 2 of 2)

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Page 2 Identifier: Requester’s Name: _____

Preferred Method of Access to Records: Receive a Copy Examine Originals at Hospital Location

Signature: _____ Date: _____

Credit Card Payment Information (if not paying by cheque)

Visa MasterCard American Express

Card Number: _____

Expiry: ____/____ Three digit security code on reverse: _____

Amount: \$: _____ Name of Cardholder: _____

Signature of Cardholder: _____

Cardholder Phone number: () _____

For Hospital Use Only

| Date Received | Request Number | Comments |
|---------------|----------------|----------|
| | | |

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