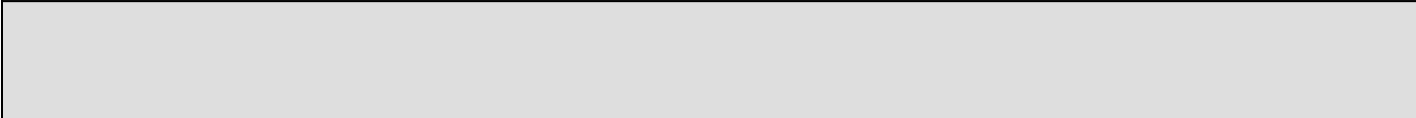
Please provide a detailed description of requested records. If you are requesting a correction of personal information, please describe the desired correction, and attach any supporting documentation. If you are requesting access to your own personal information, please include a copy of a signed form of identification.



Release of Information
Freedom of Information & Privacy Office
North York General Hospital
4001 Leslie Street,
Toronto, ON M2K 1E1

Access/Correction Request (page 2 of 2)

This request should be submitted to Release of Information, Freedom of Information & Privacy Office. Please note that a $5.00 application fee is required for all requests (cheque made payable to North York General Hospital, OR complete the credit card payment information below).

Preferred Method of Access to Records:

☐ Receive Paper Copy ☐ Receive Electronic Copy ☐ Examine Originals at Hospital

Requester's Signature: ______________________________

Date: ______________________________

Credit Card Payment Information (complete only if not paying by cheque or cash)

☐ Visa ☐ MasterCard

Card Number: ______________________________

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

Amount: $:__________ Name of Cardholder: ______________________

Signature of Cardholder: ______________________________

Cardholder Phone number: ( ) ______________________________

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Date Received	Request Number	Comments