



Access or Correction Request

Freedom of Information and Protection of Privacy Act

Request for:

Access to Personal Information Correction of Own Personal Information Other Information

Title (optional)	Last Name	First Name		
Mailing Address	Street	City/Town/Village	Province	Postal Code
Telephone Number (<i>daytime</i>)		Telephone Number (<i>evening</i>)	Cell Phone Number	
E-mail Address			Fax Number	

If request is for **access to** or **correction of**, own personal information records:

Last name appearing on records: same as above, or: _____

Please provide a detailed description of requested records, personal information or personal information that needs to be corrected. If appropriate, attach any supporting documentation. Please attach a separate sheet if you require more room.

Do you want to: receive a copy of the record? Or examine the original at WDMH?

Fee Schedule

Action	Fees
Making an access request	\$5 fee must accompany written request
Change in personal information	No fee required besides the \$5 request fee and photocopy fees
Photocopies and computer printouts	\$0.20 per page
CD ROMs	\$10 per CD
Manually searching for a record	\$30 per hour (\$7.50 for each 15 min) spent by any person
Preparing a record for disclosure, including severing part of the record	\$30 per hour (\$7.50 for each 15 min) spent by any person
Developing a computer program or other method to produce a record from a machine-readable record	\$60 per hour (\$15 for each 15 min) spent by any person
Costs, including computer costs, incurred to locate, retrieve, process and copy record(s) as specified in an invoice received by the hospital	Actual costs

- Every effort will be made to provide a fee estimate when the fee is expected to exceed \$25
 - WDMH may require the requester to pay 50% of the total estimated fee in advance if it is anticipated to exceed \$100
 - Payment of the total cost may be required before access to the record is granted
- All fees are prescribed by the Ontario Information and Privacy Commissioner

Signature : _____	Date : _____
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For Institution Use Only

Date Received	Request Number	Comments
_____	_____	_____

Personal information contained on this form is collected pursuant to the Freedom of Information and Protection of Privacy Act (FIPPA). The information provided will be used solely for the purpose of responding to your request. Questions about this collection should be directed to the Freedom of Information Co-ordinator at the Winchester District Memorial Hospital (WDMH), 566 Louise St., Winchester, Ontario, K0C 2K0.