# REQUEST TO ACCESS PERSONAL HEALTH INFORMATION FORM

| Office Use | HRN |
|---|---|
| | Date Received |

- This form is to be used when requesting personal health information about yourself or another individual you are permitted to exercise the rights of.
- Requests can be submitted by mail, fax or in person at one of the locations where care services were provided. Contact information for all sites, including hospitals, can be found on Southern Health-Santé Sud's website at www.southernhealth.ca.
- You may be required to provide two pieces of identification prior to receiving the personal health information requested.
- A base fee of **$15.00** may be applied to a request to access personal health information. Additional costs may apply (e.g. copies exceeding ten (10) pages, cost of a Universal Serial Bus (USB) or retrieval fees related to offsite storage). If additional costs apply, you will be advised of the estimate of fees and asked to accept the estimate prior to processing the request.

**Who is requesting this information?**

| | | | |
|---|---|---|---|
| ◉ | I am the individual the personal health information is about | → | Complete page 1 |
| ○ | I am **not the individual** the personal health information is about | → | Complete page 1 & 2 |

**PATIENT/CLIENT/RESIDENT INFORMATION**

| Last Name | First Name |
|---|---|
| Date of Birth (yyyy-mm-dd) | Personal Health Insurance Number (9-digit number) |

**REQUESTOR INFORMATION**

| Last Name Same as above ☐ | First Name Same as above ☐ | | |
|---|---|---|---|
| Address | City/Town | Province | Postal Code |
| | | | |

| Phone Numbers: | Home | Work | Cell |
|---|---|---|---|
| | | | |

Health records may be kept at more than one site. Please provide information about the site where the personal health information is being requested. Complete a new form for each site.

| Site/Facility/Program/Clinic (e.g. Bethesda Regional Health Centre) | City/Town *(e.g. Steinbach)* | Dates of Visit *(e.g. Mar 1-3, 2021)* | Additional Comments *(e.g. admitted for surgery)* |
|---|---|---|---|
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| | | | |

**Specific personal health information being requested:**

*(e.g. Emergency visit records, inpatient notes and operative report)*

This request is to: ☐ examine (view) **and/or** ☐ receive a copy of the information described above.

**How do you want us to get this information to you?**

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|---|---|
| ☐ | I will pick it up in person. |
| ☐ | By mail *(provide mailing address if different than above)* |
| | Mailing address: |

| Signature: *Digital signatures are not accepted* | Date: |
|---|---|
| | |

- Complete this page only when you are requesting someone else's personal health information.

**What is your relationship to the individual the personal health information is about?**

**What is your authority to access the personal health information?**

Check the appropriate box and provide a copy of the supporting documents that confirm your authority to act on behalf of the individual.

| | |
|---|---|
| ☐ | Any person with written authorization from the individual to act on the individual's behalf. |
| ☐ | A proxy appointed by the individual under *The Health Care Directives Act*. |
| ☐ | A committee appointed for the individual under *The Mental Health Act* if the committee has the power to make health care decisions on the individual's behalf. |
| ☐ | A substitute decision maker for personal care appointed for the individual under *The Vulnerable Persons Living with a Mental Disability Act* if the exercise of the right relates to the powers and duties of the substitute decision maker. |
| ☐ | The parent or guardian of an individual who is a minor, if the minor does not have the capacity to make health care decisions. |
| ☐ | If the individual is deceased, his or her Personal Representative (i.e. executor or executrix). |
| ☐ | By an attorney acting under a power of attorney granted by the individual, if the exercise of the right or power relates to the powers and duties conferred by the power of attorney. |

If it is reasonable to believe that no person listed above exists or is available, the adult person listed first in the following, who is readily available and willing to act may exercise the rights of an individual who lacks the capacity to do so:

a) the individual's spouse, or common-law partner with whom the individual is cohabitating
b) a son or daughter
c) a parent, if the individual is an adult
d) a brother or sister
e) a person with whom the individual is known to have a close personal relationship
f) a grandparent
g) a grandchild
h) an aunt or uncle
i) a nephew or niece

Ranking: The older or oldest of two or more relatives described in any clause of the above is to be preferred to another of those relatives.

**MORE INFORMATION**

- Where Visa, Mastercard or Interac is not accepted, payment can be made by cash, or a cheque made payable to Southern Health-Santé Sud.
- If you need help completing this form or submitting a request for personal health information, please contact Health Information Services at your local hospital or site where you received a health care service.
- If you require further assistance please contact the Privacy and Access Specialist.

**INTERNAL USE ONLY**

| | |
|---|---|
| Signature of Health Provider/Medical Director/Privacy Officer or Delegate | |
| Print Name: | |
| Release Date: | |
| Date Request Abandoned (if applicable): | |
| Date estimate provided: | |
| | |

Comments: