THE HEALTH INFORMATION PROTECTION ACT
Request for Access to Personal Health Information

1. APPLICANT INFORMATION

Last Name:		First Name:	
Name of Company or Organization (if applicable-optional)			
Address	City	Province	Postal Code
Day Phone Number	Alternate Number	Fax Number	Email
Trustee Name:			

2. DETAILS OF REQUEST

Please be as specific as possible in describing the records. Information you should include is the full name of the person to whom the personal health information belongs and any identifying number that relates to the records including the personal health number and/or date of birth. If you are aware of the specific time period the records were created, please specify (ex. January 2010 to June 2011).

Details of personal health information requested:

_____
_____
_____
_____
_____

3. METHOD OF ACCESS (pick one of the following)

Do you want to:

- ☐ pick up a copy of the record?
- ☐ have a copy of the record mailed to the mailing address above?
- ☐ examine the record?

4. FEES

There may be fees charged to process your request. Prior to receiving access to the records, you will be required to pay applicable fees unless they are waived.

☐ **Check if requesting waiver of fees:**

I request that payment of fees related to this request be waived because payment will cause me substantial financial hardship. Details are as follows:

5. PROOF OF IDENTITY OR AUTHORITY

If you are making a request for your own personal health information, you will have to provide proof of your identity before the records are released to you. If you are requesting records for another person, you will have to provide proof that you have the authority to act for that person before the records are released to you.

☐ I understand the above and I will provide proof of my identity or my authority to act on another person's behalf prior to records being released to me.

Signature of Applicant:
Date:

For Office Use Only	
Application Number	Date Received: