THE MEDICAL CENTRE

REQUEST TO ACCESS PERSONAL HEALTH RECORD

Information and Instructions

We will provide you with access to your personal health record unless a legal exception applies. We will review all health record access requests and will make every effort to respond to your request in a timely manner.

NAME OF PERSON REQUESTING ACCESS TO HEALTH RECORD INFORMATION:

_____

☐ Self

☐ Other

☐ Substitute Decision Maker (SDM) ***If you are the substitute decision-maker for this patient, please provide your contact information AND include copies of documents that provide your authority as a substitute decision-maker.***

Contact Information: _____

*Phone #:*_____

Part A: Patient Information

_____ _____ _____

Patient Last Name **First Name** **Initial**

Address: _____

Phone #: _____ **Date of Birth:** _____

Health Card #: _____

Part B: Access Request

1. Please describe **the information you are requesting**. **Your Physician's Name:**_____

   ☐ Immunization record

   ☐ Visit history for the last year

   ☐ Lab tests/results within _____ (*define time frame*) about _____

   ☐ Complete patient record

   ☐ Other _____

2. How do you prefer to receive this information?

- ☐ Examine originals in the facility.
- ☐ Receive a copy of the record.

Please indicate if you will pick-up the copy or prefer to have the documents mailed.

☐ pick up ☐ mail (insert mailing address)

_____

- ☐ Fax to health care provider: Fax # _____
- ☐ Mail to health care provider: (enter mailing address)

_____

3. ***I understand that there may be a fee associated with the request for this information and that I will be contacted in advance to be advised of the fee amount.***

_____ _____

Patient or SDM Name **Patient or SDM SIGNATURE**

Date: _____