

Request for access to personal health information

A. I, _____ request the Ministry of Health provide access to
name of applicant

personal information for:

_____ *patient last name (please print)*

_____ *first name*

Patient Address: _____

City: _____

Postal

Code: _____

Daytime telephone: _____

B. Person requesting access (*if different from above*): _____

_____ *last name*

_____ *first name*

Relationship to patient/legal authority* (*e.g. guardian, proxy*) _____

Address: _____

City: _____

Postal Code: _____

Daytime telephone: _____

*Attach proof that you can legally act on behalf of the patient listed above. In certain circumstances, the patient will be required to complete a Consent **for Disclosure of Personal Health Information** form.

C. To assist in the processing of this request, please provide the following additional information:

Specific information requests (including dates):

D. How do you wish to access this information? **1.** **Electronic** **OR** **2.** **Receive copies of originals:**

If #2, please choose: Pick-up Mail to address A or B Examine originals with Client Representative

You will be contacted within 30 days of the receipt of request. At that time, either the availability of the information will be confirmed or you will be informed why the information cannot be provided. Please be advised that you may be charged applicable fees related to the request.

Signature of applicant _____

Date _____

Submit requests by mail or fax to:

Chief Privacy Officer

Health Information and Privacy Unit

Partnerships and Workforce Planning Branch

Ministry of Health

3rd Floor, 3475 Albert St Regina, SK S4S 6X6

Fax: (306) 787-4534