SAMPLE — Application for Access to Personal Health Information

Disclaimer for Custodians: This is a sample form only. It may not be suitable for your circumstances and should not be relied on as legal advice.

About You

LAST NAME	FIRST NAME	
MAILING ADDRESS	CITY/TOWN	
TERRITORY/PROVINCE	POSTAL CODE	DATE OF BIRTH (YYYY-MM-DD)
CONTACT NUMBER (DAYTIME)	CONTACT NUMBER (EVENING)	
FAX NUMBER (OPTIONAL)	EMAIL ADDRESS (OPTIONAL)	

About your request

Do you want to: *(check one)* ☐ receive a copy of the records, **OR** ☐ examine the record

About the information you want to access

What records do you want to access? Please give as much detail as possible. If you need more space, please attach a separate sheet of paper.

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What is the time period of the records? Please give specific dates. *(See reverse for details)* ____________________

Your Signature

______________________ SIGNATURE

______________________ DATE (YYYY-MM-DD)

For Authorized Office Use Only

______________________ DATE ACTIVATED (YYYY-MM-DD)

______________________ RESPONSE DEADLINE (YYYY-MM-DD)

______________________ REFERENCE #

☐ IDENTIFICATION VERIFIED

☐ FEE ESTIMATE PROVIDED

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How to complete this form

If you need help completing this form, ______________________ *(the position/title of the individual responsible for responding to requests for information)* can assist you.

About you

Enter your last name and first name, complete mailing address and your daytime and evening telephone numbers. You may also enter fax number or email address where correspondence can be sent. The ______________________ *(the position/title of the individual responsible for responding to requests for information)* may need to contact you if they have any questions about your request.

About your request

1. 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. For example, we may ask to view a piece of photo identification or ask you some questions. If you are requesting records for another person, you will have to provide proof that you have the authority to act for that person. For example, you might provide proof that you are the person's guardian or trustee or that you have power of attorney for the person.
2. Do you want to receive a copy of the records or examine the records? Check the appropriate box.

About the Information you want to access

1. What personal health information are you requesting? Please be as specific as possible in describing the records. The more specific your request, the quicker and more accurately it can be answered. If you need more space, please continue your description on a separate sheet of paper and attach it to this request form.

   Please be sure that you give:

   ➡ your full name;

   ➡ any other names that you have previously used, and

   ➡ any identifying number that relates to the records, such as your personal health care card number, case number or other identification number.
2. Enter the time period of the requested records. For example, if you are requesting records for the period January 1, 1998 to August 31, 1999 enter those dates in the space provided. If you want records from August 1996 to the present, enter "August 1996 to the present."
3. You may be required to pay a per page fee for printing or photocopying (.25/page) and a service fee rate ($9.00/15 minutes) to locate, retrieve and prepare the information (N*ote: These are the maximum fees under the* Act. *The fees listed on this form should match the fees set in your policy.*) Before we start work on your request you will be told if there is a cost.

Your signature

Sign and date the form and send it to the ______________________ *(the position/title of the individual responsible for responding to requests for information)*.

Contact Information: Include mailing address, physical location, phone and fax number, email address.