PRAIRIE MOUNTAIN HEALTH

REQUEST TO ACCESS PERSONAL HEALTH INFORMATION

Please Print:

PART 1: PATIENT/RESIDENT/CLIENT INFORMATION

LAST NAME _____ FIRST NAME _____

Date of Birth: | | | | | | | | | | | (Y Y Y Y M M M D D) Health Card Number : | | | | | | | | | | |

Address: _____
Mailing Address City or Town Province Postal Code

Phone Numbers: Home: (___) _____ Work: (___) _____ Cell: (___) _____

PART 2: INFORMATION REQUESTED

Date(s) and where services provided : _____

Specify what personal health information you are requesting: _____

This is a request to: ☐ Examine (view) **and/or** → ☐ Receive a copy of the information described above

This request is for my own information: ☐ Yes ☐ No **If NO – complete Part 3**

You may be required to pay a fee to examine and/or receive a copy of the information requested.

PART 3: PERSON PERMITTED TO EXERCISE THE RIGHTS OF AN INDIVIDUAL

LAST NAME _____ FIRST NAME _____

Address: _____
Mailing Address City or Town Province Postal Code

Phone Numbers: Home: (___) _____ Work: (___) _____ Cell: (___) _____

Indicate your authority to act on behalf of the individual: _____

Note: You may be required to provide documentation to prove you have the legal authority to exercise the rights of the individual.

PART 4: WRITTEN AUTHORIZATION FOR CARE CURRENTLY BEING PROVIDED

I authorize _____ to examine and/or receive a copy of my personal health
LAST NAME FIRST NAME

information as described in Part 2 for my current episode of care only.

PART 5: SIGNATURE OF PATIENT/RESIDENT/CLIENT OR PERSON DESCRIBED IN PART 3

Signature of person making request: _____ Date: | | | | | | | | | | | (Y Y Y Y M M M D D)

<Patient Label>

Request to Access Personal Health Information (Page 2 of 2)

PRAIRIE MOUNTAIN HEALTH USE ONLY:

Date Received: Y Y Y Y M M M D D

☐ Approved

☐ A letter (R.PS1.004b) has been provided to the individual authorized to view and/or receive copies of the information.

☐ Information was reviewed in the presence of _____
Name

_____ on Y Y Y Y M M M D D
Title

☐ Copies of the following information was provided/sent to:

_____ on Y Y Y Y M M M D D
Name

_____

_____

_____

☐ Identification was verified prior to viewing and/or receiving copies of the personal health information

Partially Approved or Denied

☐ The letter (R.PSI.004c) explaining the reason for denying full access to the personal health information has been provided to the individual.

☐ A copy of the letter is attached to this request.

_____
Signature of Health Provider/Medical Director/Privacy Officer

Date: Y Y Y Y M M M D D