R.IM.PSI.005a

PRAIRIE MOUNTAIN HEALTH

REQUEST TO ACCESS PERSONAL HEALTH INFORMATION

Please Print:

PART 1: CLIENT INFORMATION

LAST NAME ____________________ FIRST NAME ____________________

Date of Birth: Y Y Y Y M M M D D

Health Card Number : (9 digits)

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: ____________________

____

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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

Place Label Here

PRAIRIE MOUNTAIN HEALTH USE ONLY:

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

☐ Approved

☐ 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 – a letter explaining the reason for partial approval has been provided to the individual and a copy placed in the health record.

☐ Denied– a letter explaining the reason for denying full access has been provided to the individual and a copy placed in the health record.

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Signature of Health Provider/Medical Director/Privacy Officer

Date: Y Y Y Y M M M D D