Providence Care

ACCESS REQUEST FOR

PERSONAL HEALTH INFORMATION RECORD

Information and Instructions

Access to your personal health information record will be provided unless a legal exception applies. All health record access requests will be reviewed and every effort will be made to respond to your request in 30 days. Please complete Parts A and B of this form, and submit to Clinical Records.

PART A: REQUESTOR INFORMATION

Client Contact Information

Surname: _____ Given Name: _____ Initial:_____

Address: _____

Telephone: _____ Date of Birth: YYYY/MM/DD

If you are a substitute decision-maker*(SDM), Power of Attorney for Personal Care (POA) or Estate Trustee if the client is deceased, your contact information:

Surname: _____ Given Name: _____ Initial: _____

Address: _____

Telephone: _____

Please provide identification and/or documentation to verify your authority as a SDM/POA/Estate Trustee

PART B: ACCESS REQUEST

Please describe below what you need and include details that will help us locate the record. (examples of dates of contact, name of care providers, etc.)

_____

_____

_____

How would you prefer to access this information?

Receive hard copies of originals Examine originals in the facility Receive secure electronic copy

Date YYYY/MM/DD Expiry date of authorization: YYYY/MM/DD

Signature: _____

*If other than client, state relationship: _____

Note: This authorization must contain the original signature of the client, the SDM/POA or the estate trustee if the client is deceased. This authorization may be rescinded in writing at any time prior to the expiration date, except where action has been taken.