**Request to Access or Disclose Personal Health Information**

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| **Program or Facility contact information:** | |
| **Address:** | |
| **Phone:** | **Fax:** |
| **Email:** | |

**Guide to Completing a Request to Access or Disclose Personal Health Information**

Personal information on this form is collected under authority of Prince Edward Island’s *Freedom of Information and Protection of Privacy Act* and *Health Information Act*, and it will be used to respond to your request. If you have questions regarding your personal health information and privacy, visit [www.healthpei.ca/yourprivacy](http://www.healthpei.ca/yourprivacy) or speak with your health care provider.

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| **Complete the following *Request to Access or Disclose Personal Health Information* form and return to the Health PEI location to which you wish to make the request.** |
| **Please note the following information;**   1. All requests for access require a clear copy of valid identification (ID);  * Provincial Health Card and * one (1) piece of photo ID *(i.e. driver’s license, passport, identification card)* ***or*** * in the absence of a photo ID; one (1) additional piece of government-issued ID without a photo that identifies date of birth *(i.e. birth certificate, marriage certificate)*  1. A fee for preparing the information may be required, depending on number of pages and record format *(i.e. paper, electronic or fax)*. 2. If you have questions or concerns regarding the personal health information that you have received, please contact your health care provider. 3. It is the responsibility of the person making the request to ensure all information provided is correct (*i.e. Mailing address, fax number, email, etc*.). 4. The location to which you submit a **Request to Access or Disclose Personal Health Information** will only be able to provide you with the records that they are able to access. There may be other records in existence at other locations. In this situation, you can submit your request to multiple locations. 5. Please complete all of the boxes on the form as appropriate, providing as much detail about what information you are requesting helps to ensure you receive the documentation you are requesting. |
| **Information regarding Substitute Decision Makers**  Prince Edward Island’s *Health Information Act* identifies who can act as a substitute decision maker and request access to another individual’s information. Substitute decision makers can include:   1. a person who has been authorized, in writing, by the individual to provide consent; 2. the individual’s personal representative, if the individual is deceased *(i.e. executor or administrator of the individual’s estate or person given authority in a Health Care Directive, etc.*);   (b) the individual’s guardian, spouse, adult child, parent, adult sibling, or any other adult next of kin of the individual; or  (h) the individual’s health care provider.  Please note that documentation is required as proof of authority to act as a substitute decision maker. |

**Request to Access or Disclose Personal Health Information**

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| 1. **About You (the person whose information is being requested)** | | | | |
| Last name: | | First name: | | |
| Date of Birth (YYYY/MM/DD): | | Personal Health Number: | | |
| Mailing address: | | | | |
| City or Town | Province | | | Postal code |
| Telephone number: | | Email address: | | |
| 1. **About your request** | | | | |
| **Whose information do you want to access?**  My own personal health information  Another person’s personal health information (See guide re: *Substitute decision makers* and attach proof that you can legally act for this person.)  I authorize the information be released to the following external party: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (Contact information for external party must be completed in Question 6). | | | | |
| 1. **About the Substitute Decision-maker (if requesting another person’s health information)** | | | | |
| Last name: | | First name: | | |
| Relationship to individual whose personal health information is being requested: | | | | |
| 1. **Which Health PEI facility, program or service are you making the request to?** (Please be as specific as possible and include the site/program name and location) | | | | |
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| 1. **About the information you want to access** | | | | |
| **What specific personal health information are you requesting to access?** (Please be as specific as possible about the records (i.e. Discharge summary, physician’s office chart, report, test results, immunization records, etc.) and include dates or time frames) | | | | |
| **Records requested:** | | | **Timeframe:** | |
| 1. **What format are you looking to have your information sent to you in?** | | | | |
| I will pick up the printed documents at the location requested.  Please mail the printed documents (specify exact mailing address to send documents, including street address, city/town, province and postal code): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Please fax the documents (specify fax # including area code) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Email the documents (specify email address – **print clearly and** **complete the acknowledgement below**) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **\*\*If requesting to receive information by email, please read and sign the following acknowledgment of risk:**  I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (print name), understand that there are risks associated with sending personal information to a private, unsecured email address, including a risk that my information could be accessed by someone else in transit. I accept the risk and request that Health PEI send my personal information to me at the email address I have provided.  Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Alternative method requested: Please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| 1. **Your Signature** | | | | |
| Signature: | | Date: | | |
| Health Care Provider consulted (if applicable): | | Date: | | |
| **For office use only** | | | | |
| Date received (YYYY/MM/DD): | | Request number: | | |
| Request Received by: | | Location: | | |
| Information Released by: | | Date released (YYYY/MM/DD): | | |