REQUEST FOR ACCESS TO PERSONAL HEALTH INFORMATION

Part A: To be Completed by Requestor

To avoid delays in processing your request, please ensure that **all** sections are completed.

Name of requestor: ____

Location/Address: ____

Telephone Number: ____

Fax Number (if applicable): ____

I am requesting personal health information concerning the following individual:

Name of Client: ____

Date of Birth: ____

MCP Number: ____

Please provide a detailed description of information being requested. Please be as specific as possible with respect to dates, types of tests/information, etc.

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Signature of Requestor:______________________________
Date: ______________________________

Please note that you are required to provide proof of identification prior to receiving information. If you are not the individual named in the request, appropriate consent of the client/patient/resident is required. Please note that this request is subject to applicable fees.

Part B: To be Completed by Western Health Staff Only

Date request received:____

Number of pages copied: ____

Date information sent:____

Signature of Western Health Staff:_____________________________________

Please place this form in the Client/Patient/Resident record once the request has been completed