Ministry of Health

Request for Access to Personal Health Information

A. I, (Name of applicant)_____ request that the Ministry of Health provide access to personal health information from (please list all relevant information including city/ town, facility/clinic, and/or physician from which you received services):

_____

Patient Name: (Please print) _____

Address: _____

City:_____Postal Code:_____Telephone#_____(daytime)

Date of birth (dd/mm/yyyy) _____ Health Services Number: _____

B. Person requesting access ***if different from above***:
Name: (Please print) _____

Relationship to Patient / Legal Authority* (e.g. guardian, proxy) _____

Address: _____

City: _____Postal Code: _____Telephone #_____

* attach proof that you can legally act on behalf of the patient listed above
In certain circumstances, a ***Consent for Disclosure of Personal Health Information*** form completed by the patient will be required.

C. To assist in the processing of this request, please provide the following additional information:
Specific information requested (including dates): _____

_____

_____

_____

_____

D. How do you wish to access this information? Please select one:
Receive copies of originals: Pick-up or Mail to address A or B (above)
Examine originals with the Client Representative

You will be contacted within 30 days of the receipt of request. At that time, either the availability of the information will be confirmed or you will be informed why the information cannot be provided. Please be advised that you may be charged applicable fees related to the request.

Signature of applicant: _____ Date: _____

Submit requests by mail or fax to: Ministry of Health
3rd Floor, 3475 Albert Street
Regina, SK S7K 0M7
Fax: (306) 787-2974