Request to Access Personal Health Information

under the *Personal Health Information Protection Act, 2004*

I hereby authorize the **C. W. Wiebe Medical Centre** to release Personal Health Information concerning

(patient name) ______________________ to

(name & phone number of recipient of records) ______________________

Please provide a detailed description of the personal health information to be released:

This authorization is effective now and will expire on the following date: ______________

Patient Identification

Surname ______________ Given Name ______________

Address ______________

City ______________ Province ______________ Postal Code ______________

Home Phone # ______________ Work Phone # ______________

If not signed by patient, please fill in Requestor Identification

Surname ______________ Given Name ______________

Address ______________

City ______________ Province ______________ Postal Code ______________

Home Phone # ______________ Work Phone # ______________

Relationship to patient:

- ☐ Parent or gaurdian of minor patient (to the extent minor could not have consented to care).
- ☐ Guardian or conservator of an incompetent patient.
- ☐ Beneficiary or personal representative of deceased patient.

Proof of legal authorization may be required.

Consent

I understand that I have the right to receive a copy of this authorization.

Signed: ______________ Dated: ______________

Print Name ______________

Administrative Use Only

Signed: ______________ Dated: ______________

Treating Physician

Patient ID # ______________

The personal health information contained on this form is collected pursuant to the Personal Health Information Protection Act, 2004 ("the Act") and will be used for the purpose of responding to your request for access pursuant to section 54 of the Act.