Personal Health Information Act

REQUEST FOR ACCESS TO PERSONAL HEALTH INFORMATION

This form will be used to request access to your own personal health records

1. IDENTIFICATION OF INDIVIDUAL (please print clearly)

Last Name	First Name	Middle initial

Previous surname (if applicable) Date of birth (YY/MM/DD)

Provincial Health Card Number

Mailing address

Daytime telephone number

2. IDENTIFICATION OF RECORDS

Please indicate which records you are seeking to access:

Please indicate what portion of the record(s) you are seeking to access:

- ☐ The whole record
- ☐ All records from the time period _____ (yyyy/mm/dd) to _____ (yyyy/mm/dd)
- ☐ The following specific records: _____

3. TERMS OF ACCESS

I wish to access the records as follows:

- ☐ View only
- ☐ Photocopies

If receiving photocopies of the records, I wish to:

- ☐ have the records delivered to me by regular mail
- ☐ have the records delivered to me by courier
- ☐ pick the records up in person

4. SIGNATURE

I consent to the **[name of custodian]** reviewing my personal health information in order to provide it to me as requested on this form. I understand that there may be a fee for access to my records, including any fee associated with delivery by regular mail or courier. The **[name of custodian]** must provide an estimate of any fees to me prior to release of my record(s), and fees may be payable by me in advance of any access.

Signature **Date**

Please deliver or mail your form to:

Jan Merrill

Phone: 902-435-0473
Fax: 902-435-5268

Alliance Dental Dartmouth

Suite 204, 635 Portland Hills Drive
Dartmouth, Nova Scotia
B2W 0J7

The personal health information requested in this form is collected pursuant to s. 75 of the *Personal Health Information Act* for the purposes of processing your request for access to your information. If you have any questions about this form or the process for requesting access, please contact [name of contact person, name of custodian].