



## Request to Access Personal Health Information

Client: \_\_\_\_\_

DOB (DD/MMM/YYYY): \_\_\_\_\_

HRN / MHSC: \_\_\_\_\_

PHIN #: \_\_\_\_\_

Place Client Label Here

### PART 1: Client Information

Last Name: _____	First Name: _____		
Date of Birth: _____ <small>(DD/MMM/YYYY)</small>	Health Card #: _____		
Address: _____			
<small>Street Name and Number</small>	<small>City</small>	<small>Province</small>	<small>Postal Code</small>
Home Phone: _____	Work Phone: _____	Cell Phone: _____	

### PART 2: Information Requested

Date(s) and where services provided: \_\_\_\_\_

Specific personal health information being requested: \_\_\_\_\_

\_\_\_\_\_

This is a request to:     examine (view) **and/or**     receive a copy of the information described above

This request is to access my own personal health information:     Yes     No **If NO - complete Part 3 Part 2A:**

Receiving a Record of User Activity to the electronic records for the time frame of \_\_\_\_\_ to \_\_\_\_\_

*You may be required to pay a fee to examine and/or receive a copy of the information requested.*

### PART 3: Alternate Decision Maker (ADM)

Last Name: _____	First Name: _____		
Address: _____			
<small>Street Name and Number</small>	<small>City</small>	<small>Province</small>	<small>Postal Code</small>
Home Phone: _____	Work Phone: _____	Cell Phone: _____	
Indicate Your Authority: (see 3 <sup>rd</sup> page) _____			
<i>You may be required to provide documentation to prove you have the legal authority to exercise the rights of the individual.</i>			

### PART 4: Written Authorization for Care Currently Being Provided Only

I authorize \_\_\_\_\_ to examine and/or receive a copy of the information described in Part 2

Last Name
First Name



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DOB (DD/MMM/YYYY): \_\_\_\_\_

HRN / MHSC: \_\_\_\_\_

PHIN #: \_\_\_\_\_

Place Client Label Here

### PART 5: Signature of Client or ADM Described in Part 3

Signature of Person making Request: \_\_\_\_\_

Date: \_\_\_\_\_  
(DD/MMM/YYYY)

### PART 6: Other

#### NORTHERN HEALTH REGION USE ONLY:

Date Received: \_\_\_\_\_ Signature of Recipient: \_\_\_\_\_  
(DD/MMM/YYYY)

- Request Approved
- Request Denied

Date of examination (viewing): \_\_\_\_\_  
(DD/MMM/YYYY)

Date Copies Provided: \_\_\_\_\_  
(DD/MMM/YYYY)

Comments \_\_\_\_\_

## **Guideline for Completion of the “Request to Access Personal Health Information (PHI) form”**

This form is to be used when a client (a patient receiving health services from a hospital, client receiving community health services, or a resident in a personal care home) requests access to their own PHI; or when a person permitted to exercise the rights of an individual requests access to PHI about the individual.

### **Part 1: Consent from Client**

- Record the last name, first name, date of birth, health card number (the 9 digit PHIN in Manitoba or another jurisdictions health card number), address (in full) and phone numbers of the individual the information is about.

### **Part 2: Information Requested**

- Specify the date(s) and where health care services were provided; include the name of the hospital, personal care home, clinic, community health centre, and/or program such as midwifery, home care, public health and mental health.
- Clearly describe the PHI requested.
- Indicate if the request is to examine the PHI, and/or to receive a copy of the PHI.
- Indicate if the request is for the individual’s own PHI, if so check “yes”, if not check “no” and complete Part 3.

### **Part 3: Alternate Decision Maker (ADM)**

- Record the last name, first name, complete address and phone numbers of the person permitted to exercise the rights of an individual the information is about.
- Indicate your authority to exercise the rights of the individual from the following list.
  - (a) any person with written authorization from the individual to act on the individual’s behalf;
  - (b) a proxy appointed by the individual under The Health Care Directives Act;
  - (c) a committee appointed for the individual under The Mental Health Act if the committee has the power to make health care decisions on the individual’s behalf;
  - (d) a substitute decision maker for personal care appointed for the individual under The Vulnerable Persons Living with a mental Disability Act if the exercise of the right relates to the powers and duties of the substitute decision make;
  - (e) an attorney acting under a power of attorney granted by the individual, if the exercise of the right or power relates to the powers and duties conferred by the power of attorney;
  - (f) the parent or guardian of an individual who is a minor, if the minor does not have the capacity to make health care decisions;
  - (g) if the individual is deceased, his or her Personal Representative.

If it is reasonable to believe that no person listed in any clause above exists or is available, the adult person listed first in the following clauses who is readily available and willing to act may exercise the rights of an individual who lacks the capacity to do so:

- the individual's spouse, or common-law partner,  
with whom the individual is cohabitating
- a son or daughter
- a parent, if the individual is an adult;
- a brother or sister;
- a person with whom the individual is known to  
have a close personal relationship;
- (f) a grandparent;
- (g) a grandchild;
- (h) an aunt or uncle;
- (i) a nephew or niece.

Ranking: The older or oldest of two or more relatives described in any clause of the above is to be preferred to another of those relatives.

#### **Part 4: Written Authorization of Care Currently Being Provided**

- Record the last name and first name of the person that the individual or person permitted to exercise the rights of an individual (as described in Part 3) has authorized to examine and/or receive a copy of the PHI described in Parts 1 and 2.

#### **Part 5: Sign off by Client or ADM Described in Part 3**

- Signature of the client or ADM as described in Parts 1 or 3.
- Date of Request

#### **Part 6: Other**

- Signature of the Recipient who received the request.
- Record the date the request was received.
- Check of if request was Approved or Denied
- Records the date the PHI was examined (viewed) and/or the date that a copy was provided
- File the completed Request to Access PHI form on the client's health record.