



REQUEST TO ACCESS PERSONAL HEALTH INFORMATION
(ce formulaire est aussi disponible en français).

PART 1: PATIENT/CLIENT/RESIDENT INFORMATION

_____ LAST NAME _____ FIRST NAME _____

Date of Birth: | | | | | | | | | | Health Card Number: | | | | | | | | | |
D D M M M Y Y Y Y Y (9 digit number)

Address: _____
STREET NAME AND NUMBER CITY PROVINCE POSTAL CODE

Phone Numbers: Home: () _____ Work: () _____ Cell: () _____

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

PART 3: PERSON PERMITTED TO EXERCISE THE RIGHTS OF AN INDIVIDUAL

_____ LAST NAME _____ FIRST NAME _____

Address: _____
STREET NAME AND NUMBER CITY PROVINCE POSTAL CODE

Phone Numbers: Home: () _____ Work: () _____ Cell: () _____

Indicate Your Authority: _____
You may be required to provide documentation to prove you have the legal authority to exercise the rights of the individual.

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

Part 5: SIGN OFF BY PATIENT/CLIENT/RESIDENT OR PERSON PERMITTED TO EXERCISE THE RIGHTS OF AN INDIVIDUAL

Signature of Person making Request: _____ Date: | | | | | | | | | |
D D M M M Y Y Y Y Y

Part 6: OTHER

Signature of Health Provider/
 Medical Director/Privacy Officer _____ Date Received: | | | | | | | | | |
D D M M M Y Y Y Y Y

Client ID/Health Record #: _____

Date of examination (viewing): | | | | | | | | | | Date copies made: | | | | | | | | | |
D D M M M Y Y Y Y Y D D M M M Y Y Y Y Y

Guideline for Completion of the "Request to Access Personal Health Information (PHI) Form"

This form is to be used when an individual (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: Patient/Client/Resident Information.

- 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 telephone 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, or 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: Person Permitted to Exercise the Rights of an Individual

- 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 maker;
 - (e) the parent or guardian of an individual who is a minor, if the minor does not have the capacity to make health care decisions;
 - (f) 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:

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

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 or receive a copy of the PHI described in Parts 1 and 2.

Part 5: Sign off by Patient/Client/Resident or Person Described in Part 3.

- Signature of the patient/client/resident or person permitted to exercise the rights of the individual as described in Parts 1 or 3.
- Date of Request.

Part 6: Other.

- Signature of the Health Provider, Medical Director or Privacy Officer who received the request.
- Record the date the request was received.
- Record 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 patient's/client's/resident's health record.