## *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: 902-679-1449
Fax: 902-679-1421

**Alliance Dental Coldbrook**

214-7165 Highway #1
Coldbrook, Nova Scotia
B4R 1B6

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].