Request for Personal Health Information

PLEASE NOTE: Your request cannot be processed until the Centre for Health Information has been able to contact you by telephone to verify your information.

To receive a copy of your personal health information, please:

- Complete the appropriate fields below and sign at the bottom,
- Include supporting documentation as required, and
- Send the completed, signed form to the **mailing address** indicated on page 3, or drop off your form in person.

PART 1: ABOUT YOU

Section A: Please complete the following information about yourself or the individual for whom you are requesting personal health information.

LAST NAME | FIRST NAME | MIDDLE INITIAL | BIRTHDATE (DD/MM/YYYY)

MCP NUMBER | MCP EXPIRY (DD/MM/YYYY) | TELEPHONE NUMBER

EMAIL ADDRESS

MAILING ADDRESS

APT/UNIT | STREET # | STREET NAME OR POST OFFICE BOX | POSTAL CODE | CITY/TOWN | PROVINCE

SECTION B: If you **do not** have an MCP Number, please fill in your health card number and issuing jurisdiction below.

HEALTH CARD NUMBER | PROVINCE, TERRITORY OR FEDERAL AUTHORITY

SECTION C: If you are **acting on behalf of another individual**, complete the following section with **your** information. Include documentation supporting your authority to act on the individual's behalf; visit our **website** or see page 3 for more information.

LAST NAME | FIRST NAME | TELEPHONE NUMBER

MAILING ADDRESS (IF DIFFERENT FROM ABOVE)

APT/UNIT | STREET # | STREET NAME OR POST OFFICE BOX | POSTAL CODE | CITY/TOWN | PROVINCE

EMAIL ADDRESS

If you are requesting information for a minor (under 16 years of age) please indicate:

1. Are you a current legal parent/guardian of the named minor child?	◯ **Yes** ◯ **No**
2. Is there more than one legal parent/guardian of the named minor child? If yes, please print their name and ensure they have signed this form. _____	◯ **Yes** ◯ **No**
3. Are there any separation agreements, court orders, or legal proceeding pertaining to the custody of, mobility of, or access to the child?*	◯ **Yes** ◯ **No**
4. Is the child currently the subject of an adoption process or partially or fully under the care of an interim, temporary, or continuous custody order?*	◯ **Yes** ◯ **No**

***If you answered yes to either question 3 or 4, please include supporting documentation.**

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PART 2: ABOUT YOUR REQUEST

Please select the type of personal health information you are requesting as well as the date range for which you would like to receive information. Please see page 3 for more information about the categories of information and the types of records which may be available. **Please note:** You may be required to pay a fee per printed page.

	FROM (DD/MM/YYYY)	TO (DD/MM/YYYY)		FROM (DD/MM/YYYY)	TO (DD/MM/YYYY)
☐ Immunization Information			☐ Medical Imaging Reports		
☐ Medication Profile			☐ Hospital Encounters		
☐ Laboratory Information					

Additional Information/Notes:

PART 3: SIGNATURE & DELIVERY

Please sign and date this form and return it to the address provided on page 3. By signing this form, you are declaring all information provided is true and complete to the best of your knowledge and that you are aware it is an offence under the **Personal Health Information Act** to willfully obtain or attempt to obtain another person's health information by falsely representing that you are entitled to the information or to willfully make a false statement to, or to mislead or attempt to mislead, a person performing duties under the **Personal Health Information Act.** If found guilty of either of these offences you may be liable on summary conviction to a fine of not more than $10,000 or to imprisonment for a term not exceeding 6 months, or both.

Your signature	Date signed (DD/MM/YYYY)	Other parent/guardian signature	Date signed (DD/MM/YYYY)

Please select your preferred method of delivery:

◯ Registered Mail ◯ In-Person Pick-Up at 70 O'Leary Avenue, St. John's ◯ Secure Email Transfer

FOR OFFICE USE ONLY

File Identification Code: _____

METHOD OF DELIVERY

◯ Registered Mail

Date Information Placed in Mail: _____

◯ Secure Email Transfer

◯ In-Person Pick-up

Date information picked up: _____

Retention Date: _____

Signature of Requestor: _____

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How do you submit this form?

By Mail:
NL Centre for Health Information
70 O'Leary Ave
St. John's, NL A1B 2C7

Please write confidential on your envelope

Due to the sensitive nature of information included with your application, you are encouraged to send it via registered mail.

The Centre for Health Information is not responsible for completed applications and supporting documentation which are lost or intercepted in transit.

Instructions for Completing the Form

The personal information collected as part of the application process is required to identify you and confirm your identity. In the case where you are requesting a medication profile on behalf of someone else, the information is also required to identify the patient and confirm that you are authorized to act on their behalf. This information is collected under the authority of the Access to Information and Protection of Privacy Act and the Personal Health Information Act. Any additional documentation collected will only be used in order to confirm identity/ authority, will not be stored, and will be returned, or destroyed if a copy is provided, by the Centre for Health Information.

Part 1: About You

Section A (about the individual's personal information):

- Complete this section using information of the person the requested information is about (yourself or the person for whom you are acting on behalf of).

Section B (if you do not have an MCP Number):

- If you do not have an MCP number, please use the health card number from your province, territory or other jurisdiction.

Section C (acting on behalf of another individual):

- An authorized representative is a person permitted to exercise the rights of an individual. This allows a trusted person to act on an individual's behalf.
- If you are requesting another individual's personal health information, please fill in Section C with your own information and fill in Section A with the individual's information.
- You may be asked to provide documentation to support your authority to request personal health information on behalf of another individual. Examples include, but are not limited to, birth certificates, letters of guardianship, letters of probate/administration. If you are requesting the personal health information of a minor (under 16 years of age), both parents/guardians will be required to sign and date the form. If you have any questions about this process, if you are unable to provide supporting documentation, or if you are unable to obtain the necessary signatures, please contact the Centre for Health Information at the number listed below.

Part 2: About Your Request

Information regarding the health information possibly available through this process can be found on our **website**. If you have questions or concerns about the medical information contained in the records you receive, you must contact the provider or RHA who created the records. The Centre is unable to provide any such information or assist in the interpretation of the records. Information available includes (circumstances may vary):

- **Immunization Information:** all immunization records and related adverse reaction information for immunizations administered at community pharmacies or by Community Health from 2003 onward.
- **Medication Profile:** the patient's most recently prescribed drugs and devices, prescription and dispense history; a list of the patient-reported non-prescribed drugs; a list of allergies and Adverse Drug Events; reported medical conditions; and any recorded Pharmacy Notes. Available from 2017 onwards and partial records between 2009-2017 (depending on when the desired pharmacy entered the Pharmacy Network)
- **Laboratory Information:** laboratory reports relating to the Blood Bank, Chemistry, Hematology, Microbiology and Pathology labs. Available form 2018 onward and partial records may be available 2015-2018 (depending on RHA location).
- **Medical Imaging Reports:** reports relating to diagnostic services such as x-rays, ultrasounds, computed tomography (CT) and mammography (reports only). Available from 2006 onward.
- **Hospital encounters:** information relating to interactions between a patient and a healthcare participant. Examples include: Outpatient visit to hospital departments, physical therapy, inpatient hospital stay, emergency room visit, physician office visit, occupational therapy, but would not include pre-admission encounters. Available form 2018 onward and partial records may be available 2015-2018 (depending on RHA location).

For copies of other records or timeframes, please contact your health care provider or the Health Authority where completed.

Part 3: Signature & Delivery

- Please sign and date the completed form
- By signing the form, you acknowledge that you have read and understood the information provided on this form and agree to:
  - have a copy made of the requested personal health information, and
  - to have that copy made available to you either via mail, in person pick-up, or secure email transfer.
- If you are requesting the personal health information of a minor, all parents/guardians will be required to sign and date the form.