

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, and
- send the completed, signed form to the mailing address indicated on page 2.

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.

You may attach documentation supporting your authority to act on the individual's behalf; see page 2 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

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 2 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 two.

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

Secure Email Transfer

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.

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, 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 NL Centre for Health Information at the number listed below.

Part 2: About Your Request

- Additional information regarding the 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 in response to your request, 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.
 - 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, all 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.
 - Laboratory Information: laboratory reports relating to the Blood Bank, Chemistry, Hematology, Microbiology and Pathology labs.
 - Medical Imaging Reports: reports relating to diagnostic services such as x-rays, ultrasounds, computed tomography (CT) and mammography (reports only).
 - 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.

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.

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.

FOR OFFICE USE ONLY

METHOD OF DELIVERY

Registered Mail

Date Information Placed in Mail: _____

Secure Email Transfer

In-Person Pick-up

Date information picked up: _____

Signature of Requestor: _____

File Identification Code: _____

Retention Date: _____