Winnipeg Regional Health Authority / Office régional de la santé de Winnipeg
Caring for Health / À l'écoute de notre santé

CancerCare Manitoba
ActionCancer Manitoba

(FRANÇAIS AU VERSO)

REQUEST TO ACCESS PERSONAL HEALTH INFORMATION

PART 1: PATIENT/CLIENT/RESIDENT INFORMATION

LAST NAME _____ FIRST NAME _____

Date of Birth: D D M M M Y Y Y Y Health Card 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 for my own 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 DESCRIBED IN PART 3

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

Date of examination (viewing): D D M M M Y Y Y Y Date Copies Provided: D D M M M Y Y Y Y

DISTRIBUTION: Original to Individual's Health Record

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(ENGLISH ON REVERSE)

DEMANDE D'ACCÈS À DES RENSEIGNEMENTS MÉDICAUX PERSONNELS

PARTIE 1 : RENSEIGNEMENTS SUR LE PATIENT/CLIENT/RÉSIDENT

NOM DE FAMILLE _____ PRÉNOM _____

Date de naissance : J J M M M A A A A

Numéro de la carte santé : _____

Adresse : _____
NOM DE RUE ET NUMÉRO MUNICIPAL VILLE PROVINCE CODE POSTAL

Nos de téléphone : Maison : ( ) _____ Travail : ( ) _____ Tél. Cell : ( ) _____

PARTIE 2 : RENSEIGNEMENTS DEMANDÉS

Date(s) et lieux de la prestation des services : _____

Renseignements médicaux personnels demandés : _____

Il s'agit d'une demande pour : ☐ examiner (consulter) **et/ou** → ☐ recevoir une copie des renseignements précisés ci-dessus.

Je demande des renseignements me concernant personnellement : ☐ Oui ☐ Non **Si la réponse est NON – remplir la Partie 3.**

Vous pourriez devoir payer des frais pour examiner et/ou recevoir une copie des renseignements demandés.

PARTIE 3 : PERSONNE AUTORISÉE À EXERCER LES DROITS D'UN PARTICULIER

NOM DE FAMILLE _____ PRÉNOM _____

Adresse : _____
NOM DE RUE ET NUMÉRO MUNICIPAL VILLE PROVINCE CODE POSTAL

Nos de téléphone : Maison : ( ) _____ Travail : ( ) _____ Tél. Cell : ( ) _____

Indiquer votre autorisation : _____

Vous pourriez devoir fournir des documents pour prouver votre autorisation légale d'exercer les droits de la personne concernée.

PARTIE 4 : AUTORISATION ÉCRITE – UNIQUEMENT POUR LES SOINS FOURNIS À L'HEURE ACTUELLE

J'autorise : _____ à examiner et à obtenir une copie des renseignements décrites dans la Partie 2.
NOM DE FAMILLE PRÉNOM

PARTIE 5 : SIGNATURE DU PATIENT / DU CLIENT / DU RÉSIDENT / DE LA PERSONNE DÉCRITE DANS LA PARTIE 3

Signature du demandeur : _____ Date : J J M M M A A A A

PARTIE 6 : AUTRES

Signature du prestataire de soins / du directeur médical / agent de protection de la vie privée : _____

Date de réception : J J M M M A A A A

Date de l'examen (consultation) : D D M M M Y Y Y Y

Date de remise des copies : D D M M M Y Y Y Y

DISTRIBUTION: Original à verser dans le dossier médical

CancerCare Manitoba
ActionCancer Manitoba

Guideline for Completing 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 jurisdiction's 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 of guardian of an individual who is 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 responsible 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
  - (b) a son or daughter;
  - (c) a parent, if the individual is an adult;
  - (d) a brother or sister
  - (e) 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 the two or more relatives described in any clause of the above is to be preferred to another of those relatives.

Part 4: Written Authorization for 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.