Royal Victoria Regional Health Centre

REQUEST ACCESS TO PERSONAL HEALTH RECORDS

Hospital Unit #_____

Account # _____

ROI # _____

OFFICE USE ONLY

Information and Instructions:

- Please complete Parts A and C if you are requesting your medical records
- Please complete Parts A, B, and C if you are a Parent/Legal Guardian/Executor/POA requesting access on behalf of a patient
- Access will be provided, unless a legal exception applies

PART A: PATIENT INFORMATION

Patient Information:

Last Name _____ First Name _____ Initials _____

Mailing Address _____ City/Town _____ Postal Code _____

Telephone Number _____ Birth Date _____

Method of Disclosure: ☐ Fax ☐ Mail ☐ Email

Fax Number: _____ Email Address: _____

Mailing Address _____ City/Town _____ Postal Code _____

(If different from above)

PART B: SUBSTITUTE DECISION MAKER (IF APPLICABLE)

Note: *Include copies of documents that provide your legal signing authority*

Last Name _____ First Name _____ Initials _____

Mailing Address _____ City/Town _____ Postal Code _____

Telephone Number _____ Relationship to Patient _____

PART C: ACCESS REQUEST

Please let us know what information you need, including dates

☐ Report(s) ☐ Imaging

☐ Labs/Pathology ☐ Date/Date Range _____

☐ Other _____

Patients/Requesters Signature _____ Patients/Requesters Name (Print) _____ Date _____

Witness Signature _____ Witness Name (Print) _____ Date _____

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