UNIVERSITY OF CALGARY

HIA-F-001 Access to Health Information

Use this form to submit a request for your own health information or if you are requesting health information on behalf of a patient/client. Requests are usually processed within 30 days. Processing time may vary depending on complexity of the request and volume of records. Fees are charged for processing a request for information.
Photo identification (ID) or two pieces of non-photo ID is required to confirm identity. If you are faxing or mailing in your request, please make sure photocopies are clear. (See reverse instructions on completion and payment)

Patient/Client Information				
Last Name		First Name		
Mailing address				
City/Town		Province	Postal Code	
Date of Birth *(yyyy-Mon-dd)*		Personal Health Number		
Representative Information				
Last Name		First Name		
Organization (if applicable)				
Phone	Address	City/Town	Province	Postal Code
Information Requested				
Indicate the records or information you want. (attach a separate sheet if you need more space)				
Time Period of Records	☐ Mail information to the above address	☐ The information will be picked up (ID Required) Note: Information is held for 2 weeks then mailed.		

Authorization

If you are requesting on behalf of the patient/client, check the box below that applies to you and attach a copy of the document that confirms your authority to act on behalf of the patient/client.

- ☐ Guardian of an individual under the age of 18 years **AND** the individual is not a mature minor.
- ☐ Guardian (or Trustee) appointed under the Adult Guardianship and Trusteeship Act, **AND** requested information relates to powers and duties of guardian or trustee.
- ☐ Nearest relative under Mental Health Act **AND** requested information is needed to carry out obligations of the nearest relative.
- ☐ Agent under the Personal Directives Act **AND** directive has been enacted **AND** requested information is relevant to a decision the agent is authorized to make.
- ☐ Personal representative of a deceased patient/client and requested information relates to administration of the individual's state.
- ☐ Power of Attorney has been granted by the patient/client AND requested information relates to powers and duties of attorney.
- ☐ Written authorization has been granted by the patient/client to make request on his/her behalf.

Requester Signature	Date (yyyy-Mon-dd)

Health information and personal information collected on this form will be used to process your request for health information. Collection of this information is authorized under section 20 of the Health Information Act and section 33 of the Freedom of Information and Protection of Privacy Act. If you have questions about the collection of ay information on this form, please contact the Clinic Privacy Officer.

Access to Health Information

How to complete the form and submit your request

Patient Information

Enter your last name and first name. If you are requesting health information for another individual (for example: your infant child; a spouse who has given you written authorization to make a request on his or her behalf), enter the name of that other individual.
Enter the date and birth and the personal health care number of the patient or individual whose health information you are requesting.

Requester information

Print your last name and first name (please print). Enter your complete mailing address and the telephone number at which you may be contacted during business hours. (Clinic staff may need to contact you if they have questions about your request).
If you are requesting your own health information, place a check mark in the “same as above” boxes for both the last name and first name.

Information Requested

Please be as specific as possible in completing this part of the form. This will assist the clinic staff in responding to your request accurately, completely and quickly.
List the records or information you are requesting as precisely as you can (for example: records relating to an outpatient visit) . Provide the name of the physician that provided the health services. Specify the time period when the patient/client received health services (this will allow staff to retrieve records relating to those services). Identify the clinic, program or clinic area that provided the services.
Sign and date your request.

Authorization

When you make a request for health information, you will be asked to provide proof of your identity before the records are provided to you. All copies of identification will be returned to you after your request has been processed. If you are requesting records for another individual, please check the box indicating the power you are exercising on behalf of the individual whose information you are requesting. Please attach evidence of your authority to exercise that power (for example: guardianship order; power of attorney; excerpts from a will naming you as executor and the date and signature of the will).

Payment

All requests for health information are subject to a fee. A basic fee of $25.00 is applied to all requests which includes up to 20 pages depending on the record format (e.g. paper, electronic or microfilmed records. Additional costs may apply as outlined in the Health Information Regulation Schedule of the Health Information Act.
Submission of Request
Submit your request by delivering in person, mailing or faxing to the Clinic Manager at the location where you received health services.
Addresses and phone/numbers for the clinic where you received health services can be found on the University of Calgary website (www.ucalgary.ca) or in the City of Calgary telephone book.