NOVA SCOTIA

Health and Wellness

Privacy and Access
Request a Record of User Activity for Your Health Records

1 Give your personal information

Last name: _____

First name: _____ Middle name: _____

Previous surname, if applicable: _____ Date of birth (yyyy/mm/dd): _____

Mailing address: _____

Postal Code: _____ E-mail address : _____

Daytime phone number: _____ Provincial health card number: _____

2 Identify the time period you are requesting*

☐ The one-year period immediately before the date of this request

☐ The period from (yyyy/mm/dd) _____ to (yyyy/mm/dd) _____

*Please note that under PHIA Regulation 11(3), a record of user activity must be kept for at least one year.

3 Identify the information system

Indicate the information system from which you require a record of user activity:

☐ SEAscape (Continuing Care)

☐ Drug Information System

☐ SHARe (Electronic Health Record)

☐ Other (please provide as much detail as possible):

_____

4 Describe how you wish to access the records

I wish to have the record of user activity

☐ delivered by regular mail (no charge)

☐ delivered by courier (charges apply)

☐ picked up in person

☐ delivered by secure file transfer to the following e-mail address: _____

☐ released to the following person or organization:

Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

5 Prove your identity with government-issued photo identification

Before releasing personal health information, the Department of Health and Wellness must check ID to verify an individual's authority to access information. If you are mailing or faxing this form, attach a clear photocopy of one piece of government-issued personal photo identification. Your photograph and signature must be clearly visible. If you are coming to our office, be prepared to show government-issued photo identification to staff.

☐ photocopy attached

☐ will present photo identification to counter staff

6 Declare your relationship to the individual

☐ self — I am requesting a report about my own health records

☐ substitute decision-maker — attach evidence of your authority to act on behalf of the patient

☐ other: _____

7 Sign the certification and consent

I **certify** that the information given on this form is complete and accurate.

I **consent** to the Department of Health and Wellness reviewing my personal health information in order to produce a record of user activity.

I **understand** that there may be a fee associated with delivery of my records if I request a courier.

Name (please print): _____

Signature: _____ Date: _____

8 Return the form and attachments to

Privacy and Access Office
NS Department of Health and Wellness
1894 Barrington Street
PO Box 488
Halifax, NS B3J 2R8

Questions? Call 902-424-5419
1-855-640-4765 (toll free)
Email: phia@novascotia.ca

For Staff Use Only

Authorized signature:

Date: _____