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AUTHORIZATION FOR ACCESS TO PERSONAL HEALTH INFORMATION

Note: This form MUST be completed in its ENTIRETY, or it will not be processed

To facilitate addressing your inquiries or administering claims, the Department of Health and Wellness, Benefits Eligibility division may require access to your personal health and billing information. If your query pertains to services received from a Canadian or international facility, we may need to investigate on your behalf or direct your concern appropriately. By signing this form, you authorize the Department of Health and Wellness, Benefits Eligibility division to collect/access and/or disclose your personal health information as necessary to assist you. Please note that you may revoke this consent at any time; however, such revocations are not retroactive.

In Nova Scotia, the Personal Health Information Act (PHIA) governs the collection, use, disclosure, retention, disposal, and destruction of personal health information. Detailed information about your rights as an individual can be found at http://novascotia.ca/dhw/phia For any questions about PHIA call 424- 5419 (Halifax) or 1-855-640-4765 (toll-free) or email PHIA@novascotia.ca

Applicant information

Current home address

_____ _____ _____ _____ _____ _____

Number Street Apt. City Prov/Terr Postal code

Mailing address (if different from current home address)

_____ _____ _____ _____ _____ _____

Number Street Apt. City Prov/Terr Postal code

Email address: _____ Telephone number: _____

I, _____ born on _____ in _____

Name of applicant (current legal name in full) (YYYY-MM-DD) City, state/province, country

authorize the Department of Health and Wellness to collect/access/use and/or disclose my personal health information to address my question(s)/concerns and/or administer claims on my behalf (we recommend at least 6 months).

from _____ to _____

(YYYY-MM-DD) (YYYY-MM-DD)

_____ _____ _____

Name of applicant (current legal name in full) Signature of applicant Date (YYYY-MM-DD)

If you are inquiring on behalf of another individual, please have the individual sign below to ensure they agree to the potential access, collection, use, and disclosure of their personal health information. *Note that personal health information about an individual will not be disclosed to another individual without consent by the individual or their substitute decision maker as authorized under the Personal Health Information Act.*

I, _____, agree that _____, can inquire on my behalf

Name of applicant (current legal name in full) Name of requestor

and my personal health information, to collect/access/use and/or disclose my personal health information to address my question(s)/concerns and/or administer claims on my behalf.

_____ _____ _____

Name of requestor (current legal name in full) Signature of requestor Date (YYYY-MM-DD)

Email: Benefit.eligibility@novascotia.ca **Fax:** 902-424-2198 **Mail:** Nova Scotia Department of Health & Wellness
Benefit Eligibility; P.O. Box 488
Halifax, NS B3J 2R8