NOVA SCOTIA

Health and Wellness

Privacy and Access
Request to Access Personal Health Information

1 Give your personal information

Last name: ______________________________

First name: ______________________ Middle name: ______________________

Previous Surname, if applicable: ______________________________

Mailing address: ______________________________

______________________________ Postal Code: ______________________

Daytime Phone Number: ______________________ E-mail Address: ______________________

2 Are you requesting your own personal health information

☐ Yes

Your Date of Birth: ______________________ Healthcard Number: ______________________

☐ No: if no, whose information are you requesting?

Name: ______________________ Relationship: ______________________

Date of Birth: ______________________ Healthcard Number: ______________________

3 Describe the records you are seeking to access

Indicate which records you are seeking to access: ______________________________

____

Indicate which portion of the record you are seeking to access:

☐ The whole record

☐ All records from the period (yyyy/mm/dd) ______________ to (yyyy/mm/dd) ______________

☐ The following specific records: ______________________________

____

4 Describe how you wish to access the records

☐ I wish to view the records only — you will be notified about when and where you can view the records

☐ I wish to receive photocopies in the following way:

- ☐ delivered by regular mail (no charge)
- ☐ delivered by courier (charges apply)
- ☐ delivered by secure e-mail
- ☐ picked up in person
- ☐ released to the following person or organization:

Name: ____________________

Address: ____________________

Phone Number: ____________________ Fax Number: ____________________

E-mail Address: ____________________

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 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 provide it to me a copy of my personal health information.

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

I **understand** that the personal health information requested in this form is collected under section 75 of the Personal Health Information Act for the purposes of processing my request for access to my information.

Name (please print): ____________________

Signature: ____________________ Date: ____________________

7 Return the form and attachments to

Health Privacy 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