Interior Health

# Freedom of Information and Protection of Privacy
# Request for Access to Personal Health Records

You may make a request for access to records without using this form, provided you do so in writing.
***Please Note:*** *The Act allows for 30 business days to provide the requested records*
Personal information contained on this form is collected under the Freedom of Information and Protection of Privacy Act and will be used only for the purpose of responding to your request.

| **Name** *(First/Middle/Last)* | **Complete Mailing Address** *(City/Town/Province/Country/Postal Code)* |
|---|---|
| **Date of Birth** *(dd/mm/yyyy)* | |
| **PHN** *(Personal Health Number/Care Card Number)* | |
| **Daytime Phone Number** | **Alternate Phone Number** |

## Purpose for the Request and Information Requested

**Please describe: the records you are requesting; the IHA Facility that hold the records; and the reason for your request.**
***Be Specific.* Attach a separate sheet if required.**

**Are you requesting access to another person's personal information?** ☐ **Yes** ☐ **No**
If ***Yes*** please attach
☐ That person's signed consent for disclosure ***OR***
☐ Proof of authority to act on that person's behalf

**Preferred Method of Delivery**
Mail ☐ Regular Canada Post
☐ Courier at requester's expense and arrangements
☐ Pick Up

Information provided to:
Name:
**Complete Mailing Address** *(City/Town/Province/Country/Postal Code)*

Contact #:

| **Requestor's Signature** | **Date Signed** *(dd/mm/yyyy)* |
|---|---|

## Please Mail or Fax Completed Form to

**The facility/program where you received your care/treatment.**
**Please go to the following link for a list of our facilities/programs**

www.interiorhealth.ca/AboutUs/InformationRequests/Documents/FOI%20Facility_Site%20List.pdf

### Interior Health Use ONLY

| **Request Number** | **Date Received** | ☐ Picture ID ☐ ID Checked By: |
|---|---|---|