Access and Disclosure
REQUEST FOR ACCESS TO PERSONAL HEALTH INFORMATION

(Please complete ALL sections of this form to avoid delays in processing your request.)

1. PATIENT/RESIDENT/CLIENT IDENTIFICATION:

Full Name

Maiden/Other Name

Health Card Number

Date of Birth (YYYY/MON/DD)

Telephone Number

❑ **Check here if this request is for the records of a deceased person. If you are seeking records for a deceased person, please include one of the following pieces of documentation:**

- ❑ A copy of the Grant of Administration or Letters of Probate for the Estate **OR**
- ❑ A copy of the pages of the Will showing you as the executor of the Will **OR**
- ❑ If there is no will, documentation of your relationship with the deceased.

2. PERSONAL OR THIRD-PARTY REQUESTS

- ❑ I am requesting access of my own personal health information.
- ❑ I am requesting access to another individual's personal information. Relationship to individual: _____
- ❑ I am authorizing the release of my information to the third-party listed below.

Name

Mailing Address

Town/City/Province

Postal Code

Phone number and email address of contact person

3. INFORMATION DESCRIPTION

❑ **Verification of Dates**	**Start Date** (YYYY/MON/DD):	**End Date** (YYYY/MON/DD):
❑ **Specific Health Records:**	**Start Date** (YYYY/MON/DD):	**End Date** (YYYY/MON/DD):
Provide as much detail as possible about the records you are seeking to access. Please list any specific facilities, programs, or providers.	Details - including name of hospital(s):	

Do you consent to your Mental Health and Addictions (MHA) records being included in this release?

❑ Yes, release these records. ❑ No, I do not wish to have these records released. ❑ N/A - I do not have MHA records.

Per the *Personal Health Information Act (PHIA),* we are required to respond within 30 days to your request once all requirements are met for the request.

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4. DELIVERY OF INFORMATION

Please specify how the requested information should be made available.

- *A copy of a government-issued photo ID must be included with this request and will also be required when picking up in person.*

❑ Email to address below via secure email transfer (recommended)

_____

❑ Mail to address in Section 2
❑ View my record in person
❑ Pick up record in person

5. CONSENT

- *Form must be signed by patient/resident/client OR an authorized representative with supporting documents when applicable.*
- *This authorization form is valid for 12 months from date of signature, unless otherwise indicated.*
- ***Mature Minors** - all patients aged 12 and over must sign their own release of information form unless they lack capacity and have a substitute decision maker.*
- ***Substitute Decision-Maker (SDM)** - supporting documents may include a Power of Attorney (POA), a Personal Directive, or Declaration of SDM. This may only be acceptable if patient is incompetent or incapable of consenting. These supporting documents are not applicable if patient is deceased.*
- ***Deceased Patient** - supporting documents may include a copy of the Will, Grant of Probate, Grant of Administration, or a Statutory Declaration.*

I consent to Nova Scotia Health (NSH) releasing the personal health information described in Section 3 (the "Records") to myself/ the Recipient listed in Section 2. I may withdraw my permission at any time, in writing, as long as the Records have not already been released. I hereby release NSH and its employees and agents from any and all claims whatsoever that may arise as a result of the release of the Records pursuant to this Release Form. I understand that NSH must provide an estimate of fees to me prior to the release of the Records and that my request will not proceed until I agree to the fees. I am personally responsible to pay any fees associated with the release, and fees are payable in advance of any access.

_____ _____

Signature of Patient or Requestor | Date (YYYY/MON/DD)

_____ _____

Signature of Witness **(Required if no copy of ID has been provided)** | Date (YYYY/MON/DD)

Relationship of Witness to Patient/Resident/Client: _____

6. ADDITIONAL INFORMATION

Queries regarding this form, process, or fees can be directed to the appropriate zone contacts as listed below.

	Central Zone Halifax Regional Municipality, Eastern Shore, and West Hants	**Eastern Zone** Cape Breton, Antigonish, and Guysborough areas	**Northern Zone** Municipality of East Hants, Colchester, Cumberland, and Pictou Counties	**Western Zone** Annapolis Valley, Southwest, and South Shore areas
Email	**APHI@nshealth.ca**	**NSHAROI@nshealth.ca**	**NSHAROI@nshealth.ca**	**NSHAROI@nshealth.ca**
Fax	902-473-2091	902-527-1722	902-527-1722	902-527-1722
Phone #	902-473-5512	902-825-4207	902-825-4207	902-825-4207

- Standard request processing fee - $30.00 plus HST; non-refundable fee payable at time of request.
- Verification of Visits/Dates -$10.00 plus HST.
- Additional fees may apply