NOVA SCOTIA

Request to Access Personal Health Information

The Department of Health and Wellness, Health Privacy Office (HPO) can assist you with accessing your records from:

- Department of Health and Wellness
- Office of Addictions and Mental Health
- Department of Seniors and Long Term Care
- Office of Healthcare Professionals Recruitment

The personal health information submitted on this form is protected by the Personal Health Information Act (PHIA) and is only collected, used or disclosed to process your request unless otherwise authorized by legislation or with your express consent.

1 Give your personal information

Last Name: _____

First Name: _____ Middle Name(s): _____

Previous Surname, if applicable: _____

Mailing address: _____

City / Town : _____ Prov _____ Postal Code: _____

Daytime Phone Number: _____ Email Address: _____

2 Identify whose personal health information you wish to access

Whose personal health information do you wish to access? (please select one):

☐ **Your own.** Your Date of Birth (yyyy/mm/dd): _____ Your Healthcard Number:_____

☐ **Someone else's information.** Last Name:_____

First Name: _____ Middle Name(s): _____

Their Relationship to You:_____

(Other than the parent of a child under the age of 16, please provide proof if you are the legal guardian or substitute decision maker)

Their Date of Birth (yyyy/mm/dd):_____ Their Healthcard Number:_____

Is this person deceased?

☐ **No.** ☐ **Yes.** If yes, please provide proof of death. If for estate purposes, please also provide proof of your authority to request the information (e.g., portion of will that identifies you as the executor/executrix).

3 Describe the records you are seeking to access

Indicate which records you are seeking to access. If the information/system isn't listed, add it to Other with as much detail as possible.

✓	Information / System	From (yyyy/mm/dd)	To (yyyy/mm/dd)	Notes
☐	List of physician visits and details / Medical Services Insurance (MSI) Billing (e.g., for life insurance claims)			
☐	Medications filled at community pharmacies / Drug Information System (DIS)			
☐	Clinical reports, lab results, x-ray/CT reports, and other electronic health record information / SHARe			
☐	Ambulance report (please include location in notes)			
☐	Other[1] (please specify):			

[1] E.g., Long-term care assessments, 811 or 911 recordings or transcripts, etc.

4 Describe how you wish to access the records (please select one)

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

I wish to receive a copy by:

☐ secure email (no charge) ☐ regular mail (no charge) ☐ courier (charges apply) ☐ picking it up in person (no charge)

I wish to release to the following person or organization:

Name of Person:_____

Name of Organization (if applicable): _____

Case Number (if applicable): _____ Phone Number: _____

☐ by secure email (no charge) Email Address: _____

☐ by regular mail (no charge) Mailing Address: _____

☐ by courier (charges apply) Civic Address: _____

☐ by fax (no charge) 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 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 by:

Mail or In Person:
Health Privacy Office
NS Department of Health and Wellness
1894 Barrington Street
PO Box 488
Halifax, NS B3J 2R8

Fax: 902-428-2267

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