REQUEST TO ACCESS PERSONAL HEALTH INFORMATION

I, ____ request that WRHA – Pan Am Clinic site, provide access to the personal health information of:

Name of Applicant

Patient: ____

Last | First | Middle

Address: ____

Street | City | Province | Postal Code

DOB: ___________________________ PHIN: _____________________________ MB Reg: _____________

DD-MMM—YYYY | 9-Digits | 6-Digits

Telephone: H: ___________________________ W: _________________________ Cell: _________________

PERSON REQUESTING ACCESS: (IF DIFFERENT FROM ABOVE)

Name: ____

Relationship to Patient: (or legal authority for request) ____

Address: ____

Telephone: H: ___________________________ W: _________________________ Cell: _____________________

PROCESSING FEES:
- **HARD COPY: $25.00 PLUS COPY FEES @ $0.50 PER PAGE**
- **CONFIRMATION OF APPOINTMENT: $10**
- **MRI CD: $35** • **SURGICAL PROCEDURE DVD: $50** • **X-RAY CD: $30**

VERY IMPORTANT

1. Specify information requested, including dates or date ranges and name(s) of care providers.

____

____

2. Indicate the reason for your request: (Optional) ____

I authorize ____ to view and/or receive copies of the above-specified personal health information in my place.

Signature of Applicant: ____ Date: __________________

The applicant will be contacted within 30 days of receipt of this request. At that time, the availability of the information will either be confirmed or the applicant will be informed that this request cannot be granted.

For Internal Purposes Only:

Date Received: ___________________________

Signature: ____ Date Processed: ___________________________

Privacy Officer or Designate

Return completed form to: **Health Information Services, Pan Am Clinic**
75 Poseidon Bay, Winnipeg, MB, R3M3E4
T: (204) 925-1528 F: (204) 925-7484