



### 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)**  
**\*YOU WILL BE REQUIRED TO PROVIDE DOCUMENTATION TO PROVE YOU HAVE THE LEGAL AUTHORITY TO EXERCISE THE RIGHTS OF THE INDIVIDUAL\***  
 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: \$15  
 \*This form is not for third party use\*

**PROCESSED BY RESPECTIVE DEPARTMENTS:**  
 • MRI CD: \$35 • X-RAY CD only: \$20 • X-RAY CD & REPORT: \$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:

Signature: \_\_\_\_\_ Date Received: \_\_\_\_\_  
 Privacy Officer or Designate Date Processed: \_\_\_\_\_

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