

## 1 Give your personal information

Last name: \_\_\_\_\_

First name: \_\_\_\_\_ Middle name: \_\_\_\_\_

Previous surname, if applicable: \_\_\_\_\_ Date of birth (yyyy/mm/dd): \_\_\_\_\_

Mailing address: \_\_\_\_\_

\_\_\_\_\_ Postal code: \_\_\_\_\_

Daytime phone number: \_\_\_\_\_ Provincial health card number: \_\_\_\_\_

## 2 Describe the records you are seeking to access

Indicate which records you are seeking to access: \_\_\_\_\_

\_\_\_\_\_

Indicate which portion of the record you are seeking to access:

The whole record

All records from the period (yyyy/mm/dd) \_\_\_\_\_ to (yyyy/mm/dd) \_\_\_\_\_

The following specific records: \_\_\_\_\_

\_\_\_\_\_

## 3 Describe how you wish to access the records

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

I wish to receive photocopies in the following way:

delivered by regular mail (no charge)

delivered by courier (charges apply)

picked up in person

released to the following person or organization:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

## 4 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

## 5 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: \_\_\_\_\_

## 6 Return the form and attachments to

Privacy and Access Office  
NS Department of Health and Wellness  
1894 Barrington Street  
PO Box 488  
Halifax, NS B3J 2R8

**Questions?** Call 902-424-5419  
1-855-640-4765 (toll free)  
Email: [phia@gov.ns.ca](mailto:phia@gov.ns.ca)

### For Staff Use Only

Authorized signature:

Date:

\_\_\_\_\_