HEALTHe
NEWFOUNDLAND AND LABRADOR

REQUEST TO ACCESS YOUR PERSONAL HEALTH INFORMATION IN HEALTHeNL

To receive a copy of your personal health information in HealtheNL, please:
- Complete the appropriate fields in the form below and sign at the bottom
- Send the signed and completed form to the mailing address indicated

PLEASE NOTE: Your request cannot be processed until the NL Centre for Health Information has been able to contact you by telephone to verify your information.

PART 1: ABOUT YOU

SECTION A: Please enter the following information about yourself or the individual for whom you are requesting information.

LAST NAME | FIRST NAME | MIDDLE INITIAL(S)

MAILING ADDRESS

APT / UNIT | STREET NUMBER | STREET NAME OR POST OFFICE BOX | POSTAL CODE

CITY/TOWN | PROVINCE | SEX (CHECK ONE)

☐ FEMALE ☑ MALE ☐ OTHER ☐ UNKNOWN

DAYTIME TELEPHONE NUMBER | CELL PHONE NUMBER | BIRTHDATE (DD/MM/YYYY) | Medical Care Plan(MCP) Number

SECTION B: If you **do not** have a MCP Number, please fill in your health card number and issuing jurisdiction below.

HEALTH CARD NUMBER | PROVINCE, TERRITORY OR FEDERAL AUTHORITY

SECTION C: If you are **acting on behalf of another individual**, complete the following section with **your** information. If you are requesting the personal health information of a minor, both parents or guardians will be asked to provide consent. See page two, Part 4 of this form.

LAST NAME | FIRST NAME | DAYTIME TELEPHONE NUMBER

MAILING ADDRESS (IF DIFFERENT FROM ABOVE)

APT / UNIT | STREET NUMBER | STREET NAME OR POST OFFICE BOX | POSTAL CODE

CITY/TOWN | PROVINCE

Why can you request this individual's information? (See page two for details)

PART 2: ABOUT YOUR REQUEST: Please select the type of medical information you are requesting from HealtheNL, as well as the date range for which you would like to receive information.

Please note: You may be required to pay a fee per printed page.

	FROM (DD/MM/YYYY)	TO (DD/MM/YYYY)		FROM (DD/MM/YYYY)	TO (DD/MM/YYYY)
☐ Immunization information			☐ Diagnostic image reports		
☐ Medication history			☐ Hospital encounters		
☐ Laboratory information			Please select the method of delivery ☑ Mail ☐ In Person Pick-up at 70 O'Leary Ave		

NOTES (OPTIONAL)

PART 3: SIGNATURE

Please sign and date this form and return it to the address or fax number provided on page two.

X _____ Your signature | DATE SIGNED (DD/MM/YYYY)

X _____ Other parent/guardian signature | DATE SIGNED (DD/MM/YYYY)

HEALTH e
NEWFOUNDLAND AND LABRADOR

Request for Personal Health Information

Instructions for Completing the Form

The personal information collected as part of the application process is required to identify you and confirm your identity. In the case where you are requesting a medication profile on behalf of someone else, the information is also required to identify the patient and confirm that you are authorized to act on their behalf. This information is collected under the authority of the *Access to Information and Protection of Privacy Act* and the *Personal Health Information Act*.

Part 1: About you

Section A (about the individual's personal information):

- Complete this section using information of the person for whom you are requesting a copy of a medication profile for (yourself or the person for whom you are acting on behalf of).

Section B (if you do not have an MCP Number):

- If you do not have an MCP number, please use the health card number from your province, territory or other jurisdiction.

Section C (acting on behalf of another individual):

- An authorized representative is a person permitted to exercise the rights of an individual. This allows a trusted person to act on an individual's behalf.
- If you are requesting the medication profile of someone else, please fill in Section C with your own information (fill in Section A with the individual's information).
- Indicate why you can request this individual's information. You must provide documentation to support your authority to do so.

Part 2: About your request

- Please indicate the type of request

Part 4: Signature

- Please sign and date the completed form
- By signing the form, you acknowledge that:

  You have read and understood the information provided on this form and agree to:

  - Have a copy of your medication profile made
  - Have the medication profile printed and made available to you either via mail or in person pick-up
- If you are requesting the profile of a minor, all parents/guardians will be required to sign and date the form.

How do you submit this form?

By Mail:
NL Centre for Health Information
ATTN: Information Request Coordinator
70 O'Leary Ave
St. John's, NL A1B 2C7
Please write confidential on your envelope

Due to the sensitive nature of information included with your application, you are encouraged to send it via registered mail.

The Centre for Health Information is not responsible for completed applications and supporting documentation which are lost or intercepted in transit.

For more information or to request forms:
Phone: (709) 752-6000
Email: inforequests@nlchi.nl.ca