



Office Use	Patient HRN
	Date Received

Health Information Access Request

- Use this form to request health information for yourself or for someone else.
- Requests can be submitted by **mail, fax or in person** to Health Information Management at one of the locations where health services were received. Fax numbers and mailing addresses for all sites can be found on our website *(or by clicking on the following link <https://www.albertahealthservices.ca/findhealth/service.aspx?id=1024504>)*.
- **All submissions require a clear copy of valid identification (ID).** Provide one of the following:
 - One (1) piece of photo ID *(eg: driver's licence, passport, identification card)*
 - or ■ Two (2) pieces of ID without a photo *(eg: health care card, birth certificate, marriage certificate)*
- A basic fee of \$25.00 is applied to all requests which includes up to 20 pages, depending on record format *(i.e. paper, electronic or microfilm record)*. Additional costs may apply.

Who is requesting this information?			
<input type="checkbox"/> I am the patient → Complete page 1			
<input type="checkbox"/> I am not the patient → Complete pages 1 & 2			
Patient Information			
Last Name		First Name	
Date of Birth <i>(yyyy-Mon-dd)</i>		Personal Health Number	
Requester Information			
Last Name <input type="checkbox"/> Same as above		First Name <input type="checkbox"/> Same as above	
Mailing Address	City/Town	Province	Postal Code
Phone Number	Signature	Date <i>(yyyy-Mon-dd)</i>	
What information do you want?			
Health records are kept at every treatment site. If you want records from more than one site, please provide information for each site . <i>(If you need more room, please attach a separate sheet)</i>			
Site/Facility <i>(eg. Queen Elizabeth II Hospital)</i>	City/Town <i>eg. Grande Prairie</i>	Clinic, Area or Program <i>eg. Emergency, Pediatrics</i>	Dates Treatment Received <i>eg. January 25-27 or January 2018</i>
What information are you looking for? <i>(Check all that apply)</i>			
<input type="checkbox"/> Discharge Summary			
<input type="checkbox"/> Emergency Room Records			
<input type="checkbox"/> Operative/Procedure Reports			
<input type="checkbox"/> Test Results <i>(eg. x-rays, lab results)</i> Specify _____			
<input type="checkbox"/> Other <i>(eg. medication lists)</i> Specify _____			
How do you want us to get this information to you?			
<input type="checkbox"/> I will pick up in person at <i>(specify AHS site)</i> _____			
<input type="checkbox"/> By mail <i>(provide mailing address if different than above)</i> _____			

Personal information collected on this form will be used to process your request for health information. Collection of this information is authorized under section 20(b) of the Health Information Act. AHS is collecting the personal health number as a custodian under section 21(1) (a) of the Health Information Act. If you have questions about the collection and use of any information on this form please contact the Disclosure Helpline at 1.855.312.2265.

Health Information Access Request

- Complete this page **only when you are requesting someone else's health information**

What is your relationship with the patient?

What is the reason for disclosure?

What is your authority to access the health information?

Check the appropriate box and provide a copy of the supporting documents that confirm your authority to act on behalf of the patient.

- The parent or legally appointed guardian of an individual under the age of 18 years AND the individual is not a mature minor.
- Guardian or trustee appointed under the Adult Guardianship and Trusteeship Act, AND requested information relates to powers and duties of guardian or trustee.
- Nearest relative under the Mental Health Act AND requested information is needed to carry out my obligations as the nearest relative.
- Agent under the Personal Directives Act AND directive has been enacted AND requested information is relevant to a decision the agent is authorized to make.
- Personal representative of a deceased individual AND requested information relates to administration of the individual's estate.
- Power of attorney has been granted by the individual AND requested information relates to powers and duties of attorney.
- Written authorization has been given by the individual to make request on his/her behalf.

More Information

- AHS accepts payment by cheque or money order, payable to Alberta Health Services
- If you need help submitting a request for information, contact Health Information Management at your local hospital or health care centre where you received treatment.
- If you require further assistance, please contact the Disclosure Help Line by phone 1.855.312.2265 or by email at disclosure@ahs.ca.