northern health
the northern way of caring

All sites and facilities

Mature Minor Requesting Their Health Records

Last Name:
First Name (Preferred Name):
Encounter number: NH Number: Chart Created: Y/N
Date of Birth: Gender: Age: Encounter Type:
Responsibility for Payment: PHN:
Primary Care Physician/Attending Physical:
PATIENT LABEL

Personal information contained on this form is collected under The Freedom of Information and Protection of Privacy Act and will be used only for the purpose of responding to your request.

I would like to request unrestricted access to my personal health information contained within HealtheLife/ Health Record:

Name (First/Middle/Last): _____

Date of Birth: (dd/mm/yyyy): _____

PHN (Provincial Health Number/Care Card): _____

Day Phone: _____ Email: _____

Mailing Address: _____

City/Town: _____ Province: _____

Country: _____ Postal Code: _____

SECTION BELOW TO BE COMPLETED BY A PHYSICIAN, NURSE PRACTITIONER, OR PSYCHOLOGIST

The Minor above has requested to have unrestricted access to his/her Personal Health Record via the Northern Health Patient Portal - HealtheLife/Health Record.

HealtheLife is an online web-based system that displays current available information contained in the Northern Health Enterprise Information System (Cerner). Additional information will be made available in the future.

As his/her Health Care Provider, you are requested to complete this form to confirm that the minor is sufficiently mature and capable to understand the information contained in their Personal Health Record.

A Minor is defined as anyone under the Age of Majority (19 years in B.C.)

I confirm as of this date that this Patient, _____, is sufficiently mature / capable to have unrestricted access to their personal health information contained within HealtheLife/Health Record:
(name of patient)

Health Care Provider Name (First/Middle/Last): _____

Health Care Provider Specialty (Profession or Society): _____

MSP _____

Signature: _____

Date: _____ Phone Number: _____

Mailing Address: _____

City/Town: _____ Province: _____

Country: _____ Postal Code: _____

Note: The signing of this form is for Information Access only; it does not apply for Emergency Health Care or Treatment.
Minors have the option to request access to their health care record information at the Health Records Department of their local NH facility.
The minor is to present this form and identification to health records for verification.

Print name: _____ Date: _____
(patient name)

Signature: _____
(patient signature)