northern health
*the northern way of caring*

All Sites and Facilities

# Request for Release of Health Records



**Office Use Only**

Medical Record Number (if available): _____ Request No.: _____

**Please fax or mail your completed request to the Northern Health facility you are requesting records from**

- Use this form to request health information for yourself or for someone else
- Requests must be submitted by mail or fax only. Please address all requests to Health Information Management, and fax or mail it to the health care facility where you received health care services. Fax numbers and mailing addresses for all sites can be found on the Northern Health website under 'Find a Facility'
- All documentation must contain original signatures. (Electronic signatures, Digital images, or pictures of requests are not accepted)
- All requests for release of information must be signed and dated after treatment has occurred
- Diagnostic report results may also be accessed via HealthELife or Health Gateway. Sign up today!

## Part 1. Patient Information

| Last Name: | First Name: | Also Known As/Alias: | |
|---|---|---|---|
| Mailing Address: | | | |
| City: | Province: | Country: | Postal Code: |
| Telephone No: | Date of Birth (DD / MM / YYYY): | Personal Health Card No.: | |

## Part 2. Records Requested

Name of Hospital(ie UHNBC, Fort St John Hospital etc)/Facility:

| | | |
|---|---|---|
| ☐ Discharge Summary/Consults | ☐ Emergency Visit | ☐ Diagnostic Reports (Lab / Radiology)<br>☐ Test Results |
| ☐ Confirmation of Visit (s) Letter (Fees may apply) | ☐ Outpatient<br>☐ OR Reports/Procedures | ☐ Other (Please Specify): |

Date(s) of Record Request: **From:** **To:**

- If you do not know the exact date(s), please provide your best estimate
- If you have questions regarding your request, please contact the facility where you received care. See above for link to website

## Part 3. Person/Organization/Company Receiving Records

| ☐ Myself ☐ Name of Person Receiving Records<br>**Last Name:** **First Name:** | Name of Company/Organization (if applicable): | |
|---|---|---|
| Mailing Address: | | |
| Telephone No: | Fax No: | |
| City: | Province: | Country: | Postal Code: |

* For patients between 12 and 18 years of age who wish to obtain their own records, please consult the Health Information Management in your community for guidance regarding the requirements of the BC Infants' Act.

## Part 4 Authorization
Patient Authorization (19 and older)

I, the patient, authorize the Hospital/Facility to release the records requested to the person named in the 'Person Receiving Records' section above.

| Signature of Patient: | Date Signed (DD / MM / YYYY): |
|---|---|

- Co-authorization for Capable Patients between the age of 12-18 years of age. (Requestor and Patient must both sign if the Patient is between 12-18 years of age)

| Signature of Patient: | Date Signed (DD / MM / YYYY): |
|---|---|
| Signature of Requestor: | Date Signed (DD / MM / YYYY): |

## Part 5. Authorization on Behalf of Patient (Please complete page 3 of form)
(If the patient is under 12 years of age or unable to authorize the release of personal information)

By signing below, I confirm that I have legal authority to act on behalf of the patient and I hereby authorize the Hospital/Facility to release the records requested to the person named in the 'Person Receiving Records' section above

If applicable, I have attached documentation to show my status as the legal representative or guardian (e.g. copy of Will, Court Order, Legal Agreement, or other documentation)

| Reason for Request: | |
|---|---|
| Full Name: | |
| Signature: | Date Signed (DD / MM / YYYY): |

# Request for Release of Health Records



**Complete this section only if Part 5 above was completed**

## Authorization on Behalf of an Incapable Adult

Any of the following, acting within their duties or powers, may provide authorization on behalf of an adult:

- ☐ **Committee** appointed by court order (where records are required to carry out committee's duties)
- ☐ **Litigation Guardian** (where records are required for litigation)
- ☐ **Representative** under a Representation Agreement (where records are required to carry out representative's duties)

*If none of the above have been appointed, please explain relationship to patient and intended use of the records:*

## Authorization on Behalf of an Incapable Minor

Complete this section if the patient is a minor

- Under 12; or
- Under 19 and not actively involved or capable of making decisions about their health care

**Guardian:** Copy of proof is required

- ☐ By court order
- ☐ Under a legal agreement
- ☐ Parent who has lived with or regularly cared for the child(ren) and there is no order or agreement removing my guardianship

## Authorization on Behalf of a Deceased Patient

**Deceased adult:**

- ☐ **Executor or Administrator of Estate** – Proof is required (copy of Will)
- ☐ If there is no **Executor or Administrator of Estate, Committee of Person** (appointed by court order)

  If there is no Executor, Administrator of Estate or Committee:

  Nearest Relative: first person referred to in the following hierarchy who is willing and able to act on behalf of the deceased:

  - ☐ Spouse
  - ☐ Adult child
  - ☐ Parent
  - ☐ Adult sibling
  - ☐ Other (please specify):

**Deceased Minor (under 19):**

**Legal Guardian** (appointed by court, under an agreement, or a parent who has lived with or regularly cared for the child)

If there is no Legal Guardian:

Nearest Relative: first person who is willing and able to act on behalf of the deceased

- ☐ Spouse
- ☐ Parent
- ☐ Adult sibling
- ☐ Other (please specify):

*This authorization must be signed by the patient/resident/authorized representative and must be dated within 6 months of the request being submitted. Requests will be completed as per the BC Freedom of Information and Protection of Privacy Act (FIPPA).*

*Personal information contained on this form is collected under s. 26 of FIPPA and will be used only for the purpose of responding to your request. If you have questions, please contact the Health Information Management.*