MOUNT CARMEL CLINIC

Guideline for Completion of the "Request to Access Personal Health Information (PHI) Form"

This form is to be used when an individual (a patient receiving health services from a hospital, client receiving community health services or a resident in a personal care home) requests access to their own PHI; or when a person permitted to exercise the rights of an individual requests access to PHI about the individual.

Part 1: Patient/Client/Resident Information.

Record the last name, first name, date of birth, health card number (the 9 digit PHIN in Manitoba or another jurisdictions health card number), address (in full) and telephone numbers of the individual the information is about.

Part 2: Information Requested.

- Specify the date(s) and where health care services were provided; include the name of the hospital, personal care home, clinic, community health centre, and/or program such as midwifery, home care, public health and mental health.
- Clearly describe the PHI requested.
- Indicate if the request is to examine the PHI, or receive a copy of the PHI.
- Indicate if the request is for the individual's own PHI, if so check "yes", if not check "no" and complete Part 3.

Part 3: Person Permitted to Exercise the Rights of an Indivdiual

Record the last name, first name, complete address and phone numbers of the person permitted to exercise the rights of an indivdiual the information is about
Indicate your authority to exercise the rights of the indivdiual from the following list.

A) Any person with written authorization from the indivdiual to act on the indivdiual's behalf;
B) A proxy appointed by the indivdiual under the Health Care Directives Act;
C) A committee appointed for the indivdiual under the Mental Health Act if the committee has the power to make health care decision on the indivdiual's behalf;
D) A substitute decision maker for persoan care appointed for the indivdiual under the Vulnerable Persons Living with a Mental Disabiltiy Act if the exercise of the rigth relates to the powers and duties of the substitute decision maker;
E) The parent or guardian of an indivdiual who is a minor, if the minor does not have the capacity to make health care decisions;
F) If the indivdiual is deceased, his or her Personal Representative

If it is reasonable to beleiive that no person listed in any clause above exists or is available, the adult person listed first in the the following clauses who is readily available and willing to act may exercise the rights of an indivdiual who lacks the capacity to do so:

A) The indivdiual's spouse, or common-lawpartner, with whom the indivdiual is cohabiting
B) A son or daughter;
C) A parent, if the indivdiual is an adult;
D) A brother or sister;
E) A person with whom the indivdiual is known to have a close personal relationship
F) A grandparent;
G) A grandchild
H) An aunt or uncle
I) A nephew or niece

Ranking: The older or oldest of two or more relatives described in any clause of the above is to be preferred to another of those relatives.

Part 4: Written Authorization for Care Currently Being Provided:

Record the last name and first name of the person that the individual or person permitted to exercise the rights of an individual (as described in Part 3) has authorized to examine or receive a copy of the PHI described in Parts 1 and 2.

Part 5: Sign off by Patient / Client or Person Described in Part 3.

- Signature of the patient / client or person permitted to exercise the rights of the individual as described in Parts 1 or 3
- Date of request

Part 6: Other

- Signature of the Health Provider, Medical Director or Privacy Officer who received the request
- Record the date the request was received
- Record the date the PHI was examined (viewed) and/or the date that a copy was provided
- File the completed Request to Access PHI form on the patient's/client's health record

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REQUEST TO ACCESS PERSONAL HEALTH INFORMATION

PART 1 PATIENT / CLIENT INFORMATION

Last Name: _____ First Name: _____

Date of Birth DD/MM/YYYY:_____

Address: Street Name & Number / City / Province / Postal Code: _____

Phone Numbers: Home: ( ) _____Work: ( ) _____ Cell: ( ) _____

PART 2 INFORMATION REQUESTED

Date(s) and where services provided: _____

Specific personal health information being requested: _____

This is a request to: ☐ examine (view) and/or ⇨ ☐ receive a copy of the information described above.

This request is for my own information: ☐ Yes ☐ No If NO – complete Part 3

You may be required to pay a fee to examine and/or receive a copy of the information requested.

PART 3 PERSON PERMITTED TO EXERCISE THE RIGHTS OF AN INDIVIDUAL

Last Name: _____ First Name: _____

Address: Street Name/Number/City/Province/Postal Code:_____

Phone Numbers: Home: ( ) _____ Work: ( ) _____ Cell: ( ) _____

Indicate Your Authority: _____

You may be required to provide documentation to prove you have the legal authority to exercise the rights of the individual.

PART 4: WRITTEN AUTHORIZATION FOR CARE CURRENTLY BEING PROVIDED ONLY:

I authorize: _____ (Last Name and First Name) to examine and/or receive a copy of the information described in Part 2

PART 5: SIGN OFF BY PATIENT/CLIENT OR PERSON DESCRIBED IN PART 3

Signature of Person Making Request: _____ Date: _____ dd/mm/yyyy

PART 6: OTHER

Signature of Health Provider/Medical Director/Privacy Officer: _____

Date Received: _____dd/mm/yyyy

Date of examination (viewing):_____ dd/mm/yyyy

Date copies provided: _____dd/mm/yyyy