

Use this form to submit a request for your own health information or if you are requesting health information on behalf of a resident/client. Requests are usually processed within 30 days. Processing time may vary depending on complexity of the request and volume of records. **Fees are charged for processing a request for information. See reverse for instruction on completion and payment.**

Photo identification (ID) or two pieces of non-photo ID is required to confirm identity. If you are faxing or mailing in your request, please make sure photocopies are clear.

Resident/Client Information	
Last Name	First Name
Birthdate <small>(YYYY/MM/DD)</small>	Personal Health Number

Requester Information <input type="checkbox"/> Same as above			
Last Name	First Name		
Mailing Address			
City/Town	Province	Postal Code	Phone

Information Requested		
Name of Carewest Facility	Unit/Program or Area of Service	Time Periods of Records

Indicate the records or information you want (attach a separate sheet of paper if you need more space)

Mail information to above address The information will be picked up (ID required) Notes: Information is held for 2 weeks then mailed

Complete this section only when you are requesting someone else's health information

What is your relationship to the resident/client?

What is the reason for disclosure?

Health information and personal information collected on this form will be used to process your request for health information. Collection of this information is authorized under section 206(1) of the Health Information Act and section 33(1) of the Freedom of Information and Protection of Privacy Act. Carewest is collecting the personal health number under section 21(1) (a) of the Health Information Act. If you have questions about the collection of any information on this form please contact Carewest Information Management & Privacy by phone at (800) 230-6900.