Carewest
INNOVATIVE HEALTH CARE

Health Information Access Request

(Information Management & Privacy)

Office Use Only
Carewest Unique Number

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 (YYYY/Mon/DD)		Personal Health Number	
Requester Information ☐ 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) Note: 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 20(b) of the Health Information Act and section 33(c) 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 (403) 230-6900.

Health Information Access Request

Authorization
If you are requesting on behalf of the resident/client, check the box below that applies to you and attach a copy of the document that confirms your authority to act on behalf of the resident/client.
☐ 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 obligations of 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 resident/client **AND** requested information relates to administration of the individual's estate.
☐ Power of attorney has been granted by the resident/client **AND** requested information relates to powers and duties of attorney.
☐ Written authorization has been given by the resident/client to make request on his/her behalf.

Requester Signature	Date (YYYY/Mon/DD)

How to complete the form and submit your request

Resident/Client information
Enter your last name and first name. If you are requesting health information for another individual (for example: your spouse or parent who has given you written authorization to make a request on his/her behalf), enter the name of that other individual. Enter the date of birth and the personal health care number of the individual whose health information you are requesting.

Requester Information
Print your last name and first name (please print). Enter your complete mailing address and the telephone number at which you may be contacted during business hours. (Carewest Information Management and Privacy staff may need to contact you if they have questions about your request). If you are requesting your own health information, place a check mark in the "same as above" box.

Information Requested
Please be as specific as possible in completing this part of the form. This will assist Carewest in responding to your request accurately, completely and quickly. List the records or information you are requesting as precisely as you can (for example: records relating to my stay on Neuro Rehabilitation). Provide the name of the Carewest Facility that provided the health services (for example: Dr. Vernon Fanning Centre). Identify the Unit/Program or area that provided the services (for example: RCTP). Sign and date your request.

Authorization
When you make a request for health information, you will be asked to provide proof of your identity before the records are provided to you. All copies of identification will be returned to you after your request has been processed. If you are requesting records for another individual, please check the box indicating the power you are exercising on behalf of the individual whose information you are requesting. Please attach evidence of your authority to exercise that power (for example: guardianship order; power of attorney; excerpts from a will naming you as executor and the date and signature of the will).

Payment
All requests for health information are subject to a fee. A basic fee of $25.00 is applied to all requests which includes up to 20 pages. Every page after that costs 0.25 cents per page. Additional costs may apply as outlined in the Health Information Regulation Schedule of the Health Information Act. Carewest accepts payment by cheque, payable to Alberta Health Services.

Submission of Request
Submit your request by faxing, mailing or delivering in person to:

Carewest Information Management & Privacy
Carewest Dr. Vernon Fanning
722 – 16th Avenue N.E.
Calgary, Alberta, T2E 6V7
FAX (403) 230-6995