# Access and Disclosure

## REQUEST FOR ACCESS TO PERSONAL HEALTH INFORMATION

*(Please complete ALL sections of this form to avoid delays in processing your request.)*

### 1. PATIENT/RESIDENT/CLIENT IDENTIFICATION:

Full Name

Maiden/Other Name

Health Card Number

Date of Birth (YYYY/MON/DD)

Telephone Number

❑ **Check here if this request is for the records of a deceased person (additional documents may be required).**

### 2. PERSONAL OR THIRD-PARTY REQUESTS

❑ I am requesting access of my own personal health information.

❑ I am requesting access to another individual's personal information. Relationship to individual: _____

❑ I am authorizing the release of my information to the third party listed below.

Name

Mailing Address

Town/City/ Province

Postal Code

Phone number and email address of contact person

### 3. INFORMATION DESCRIPTION

| | | |
|---|---|---|
| ❑ **Verification of Dates** | **Start Date** (YYYY/MON/DD): | **End Date** (YYYY/MON/DD): |
| ❑ **Specific Health Records:** | **Start Date** (YYYY/MON/DD): | **End Date** (YYYY/MON/DD): |
| Provide as much detail as possible about the records you are seeking to access.<br><br>Please list any specific facilities, programs, or providers. | Details: | |

**Do you consent to your Mental Health and Addictions (MHA) records being included in this release?**

❑ Yes, release these records. ❑ No, I do not wish to have these records released. ❑ N/A - I do not have MHA records.

### 4. DELIVERY OF INFORMATION

**Please specify how the requested information should be made available.**

- *A copy of a government-issued photo ID must be included with this request and will also be required when picking up in person.*

❑ Email to address below via secure email transfer (recommended)

Email address

❑ Mail to address in Section 2

❑ View my record in person

❑ Pick up record in person

Per the *Personal Health Information Act (PHIA),* we are required to respond within 30 days to your request once all requirements are met for the request.

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### 5. CONSENT

- *Form must be signed by patient/resident/client OR an authorized representative with supporting documents when applicable.*
- *This authorization form is valid for 12 months from date of signature, unless otherwise indicated.*
- ***Mature Minors** - all patients aged 12 and over must sign their own release of information form unless they lack capacity and have a substitute decision maker.*
- ***Substitute Decision-Maker (SDM)** - supporting documents may include a Power of Attorney (POA), a Personal Directive, or Declaration of SDM. This may only be acceptable if patient is incompetent or incapable of consenting. These supporting documents are not applicable if patient is deceased.*
- ***Deceased Patient** - supporting documents may include a copy of the Will, Grant of Probate, Grant of Administration, or a Statutory Declaration.*

I consent to Nova Scotia Health (NSH) releasing the personal health information described in Section 3 (the "Records") to myself/ the Recipient listed in Section 2. I may withdraw my permission at any time, in writing, as long as the Records have not already been released. I hereby release NSH and its employees and agents from any and all claims whatsoever that may arise as a result of the release of the Records pursuant to this Release Form. I understand that NSH must provide an estimate of fees to me prior to the release of the Records and that my request will not proceed until I agree to the fees. I am personally responsible to pay any fees associated with the release, and fees are payable in advance of any access.

Signature of Patient or Requestor _____ Date (YYYY/MON/DD) _____

Signature of Witness _____ Date (YYYY/MON/DD) _____

Relationship of Witness to Patient/Resident/Client: _____

### 6. ADDITIONAL INFORMATION

Queries regarding this form, process, or fees can be directed to the appropriate zone site and/or contacts as listed below.

| | **Central Zone**<br>Halifax Regional Municipality, Eastern Shore, and West Hants | **Eastern Zone**<br>Cape Breton, Antigonish, and Guysborough areas | **Northern Zone**<br>Municipality of East Hants, Colchester, Cumberland, and Pictou Countries | **Western Zone**<br>Annapolis Valley, Southwest, and South Shore areas |
|---|---|---|---|---|
| **Email** | **APHI@nshealth.ca** | **NSHAROI@nshealth.ca** | **NSHAROI@nshealth.ca** | **NSHAROI@nshealth.ca** |
| **Fax** | 902-473-2091 | 902-527-1722 | 902-527-1722 | 902-527-1722 |
| **Mailing Address and Phone #** | **Halifax Office**<br>Attn: Access and Disclosure<br>1-031 Centennial Building<br>1276 South Park Street,<br>Halifax, NS B3H 2Y9<br>902-473-5512 | **Cape Breton Regional Hospital**<br>Attn: Access and Disclosure<br>1482 George Street<br>Sydney, NS B1P 1P3<br>902-567-7214<br><br>**St. Martha's Regional Hospital**<br>Attn: Access and Disclosure<br>25 Bay Street<br>Antigonish, NS B2G 2G4<br>902-867-4500 ext. 4189 | **Aberdeen Regional Hospital**<br>Attn: Access and Disclosure<br>835 East River Road<br>New Glasgow, NS B2H 3S6<br>902-752-7600 ext. 2225<br><br>**Colchester East Hants Health Centre**<br>Attn: Access and Disclosure<br>600 Abenaki Road<br>Truro, NS B2N 5A1<br>902-893-5554 ext. 42489 | **South Shore Regional Hospital**<br>Attn: Access and Disclosure<br>90 Glen Allan Drive<br>Bridgewater, NS B4V 3S6<br>902-543-4604, ext. 2489<br><br>**Valley Regional Hospital**<br>Attn: Access and Disclosure<br>150 Exhibition Street<br>Kentville, NS B4N 5E3<br>902-679-2657<br>ext. 2182 or 2192 |

- Standard request processing fee - $30.00 plus HST; non-refundable fee payable at time of request.
- Verification of Visits/Dates -$10.00 plus HST.
- Additional fees may apply