DALHOUSIE UNIVERSITY

STUDENT HEALTH & WELLNESS CENTRE

REQUEST FOR ACCESS TO PERSONAL HEALTH INFORMATION

This form will be used to request access to your own personal health records

1. IDENTIFICATION OF INDIVIDUAL (please print clearly)

Last Name | First Name | Middle initial

Previous surname (if applicable) | Date of birth (YY/MM/DD)

Provincial Health Card Number or Private Insurance Identifier

Mailing address

Daytime telephone number

2. IDENTIFICATION OF RECORDS

Please indicate which records or portion of records you are seeking to access to:

- ☐ Access to counselling history only
- ☐ Access to medical history only
- ☐ Access to specific test results _____
- ☐ Access to immunization records
- ☐ Access to complete health records chart
- ☐ All records from the time period _____ (yyyy/mm/dd) to _____ (yyyy/mm/dd)

- ☐ The following specific records: _____

3. TERMS OF ACCESS

I wish to access the records as follows:

- ☐ View only
- ☐ Photocopies

1246 LeMarchant Street, Suite 2501 • PO Box 15000 • Halifax NS • B3H 4R2 • Canada
Tel: 902-494-2171 • Fax: 902-494-6872 • dal.ca/studenthealth

If receiving photocopies of the records, I wish to:

- ☐ have the records delivered to me by regular mail at the address above
- ☐ have the records delivered to me by courier
- ☐ pick the records up in person
- ☐ authorize the release to another individual
  - ○ **I authorize the release of information to the following person(s):**
    Name of person/organization to receive the information

    _____

    Address_____

    Telephone Number_____

    Fax Number_____

4. SIGNATURE

Relationship to the individual (please check one)

○ *Self* ○ *Substitute Decision Maker* ○ *Other*_____

Dalhousie Student Health & Wellness is required to verify an individual's authority to access information before releasing personal health information. A clear photocopy of one piece of government issued personal identification will be required for fax/mail requests (ensure photocopy shows your photograph and your signature).

I consent to my physician, psychiatrist, psychologist, counsellor, or social worker reviewing my personal health information in order to provide it to me as requested on this form. I understand that there may be a fee for access to my records, including any fee associated with delivery by regular mail or courier. Dalhousie Student Health & Wellness will provide an estimate of any fees to me prior to release of my record(s), and fees will be payable by me in advance of any access.

Signature **Date**

Please deliver or mail your form to:
Dalhousie Student Health & Wellness
1246 LeMarchant St, 2nd floor
Halifax, Nova Scotia B3H 4R2
Phone: 902-494-2171
Fax: 902-494-6872

Office use only: Date Request Received_____ Date Record Provided_____