

Release of Information Request Form

The information on this form will be used to respond to your request for your own health information.

SECTION A: APPLICANT INFORMATION

<input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr. Last Name		First Name	
<input type="checkbox"/> Mrs. <input type="checkbox"/> Miss			
Mailing address			
City or town		Province	Postal code
Telephone (business) ()	Telephone (home) ()	Fax Number ()	E-mail address
Date of Birth (day)(month)(year)		Other	

SECTION B: DETAILS OF THE REQUEST

1. Please attach the initial fee of \$25.00.
2. Do you want to: (a) receive a copy of the record? **OR** (b) examine the record?
3. What records do you want to access? Please give as much detail as possible. Indicate if you also want access to records about the disclosure of your information. *(Be sure to give all your previous names. If you are requesting access to another individual's information, you must include, in the box below, information to identify the individual and attach proof that you can act for that individual as an authorized representative under section 104 of the Alberta Health Information Act or as the Personal Spokesperson appointed by the individual's family members. If you need more space, please attach a separate sheet of paper.)*

4. What is the time period of the records? Please give specific dates.

SECTION C: SIGNATURE

Signature	Date
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For authorized office use only:

Date Received	Request Number