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. 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 Halifax Regional Municipality, Eastern Shore, and West Hants	**Eastern Zone** Cape Breton, Antigonish, and Guysborough areas	**Northern Zone** Municipality of East Hants, Colchester, Cumberland, and Pictou Countries	**Western Zone** 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** Attn: Access and Disclosure 1-031 Centennial Building 1276 South Park Street, Halifax, NS B3H 2Y9 902-473-5512	**Cape Breton Regional Hospital** Attn: Access and Disclosure 1482 George Street Sydney, NS B1P 1P3 902-567-7214 **St. Martha's Regional Hospital** Attn: Access and Disclosure 25 Bay Street Antigonish, NS B2G 2G4 902-867-4500 ext. 4189	**Aberdeen Regional Hospital** Attn: Access and Disclosure 835 East River Road New Glasgow, NS B2H 3S6 902-752-7600 ext. 2225 **Colchester East Hants Health Centre** Attn: Access and Disclosure 600 Abenaki Road Truro, NS B2N 5A1 902-893-1456	**South Shore Regional Hospital** Attn: Access and Disclosure 90 Glen Allan Drive Bridgewater, NS B4V 3S6 902-543-4604, ext. 2489 **Valley Regional Hospital** Attn: Access and Disclosure 150 Exhibition Street Kentville, NS B4N 5E3 902-679-2657 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