



SUN COUNTRY HEALTH REGION
&
AFFILIATES

Request to Access Personal Health Information

Whose information do you want access to? (check appropriate box)

- My own information
Another person's personal information

Please complete the "Individual's Information" and "Access by Authorized Representative" sections below, and attach proof that you can legally act on behalf of the individual.

INDIVIDUAL'S INFORMATION

NAME OF INDIVIDUAL: Birthdate:

ADDRESS: Hospitalization No.:

INFORMATION REQUESTED: (include dates)

Please describe in as much detail as possible, the information you want access to.

Multiple horizontal lines for describing requested information.

(Print Name of Witness)

(Signature of Individual)

(Witness to Signature)

Date:

(Access by Authorized Representative Section - see over page)

Access by Authorized Representative:

I am a legally authorized representative of the individual named above and have attached proof of that representation. I hereby request access to the individual's personal health information on his or her behalf.

Name of Authorized Representative: _____

Full Address: _____

Home Phone Number: _____

(Print Name of Witness)

(Signature of Authorized Representative)

(Signature of Witness)

Date: _____

For Sun Country Health Region Staff Only:

INFORMATION PROVIDED:

I hereby certify that I have provided the above information.

- In person By mail By fax By phone By viewing

(Printed Name and Position of Health Care Representative)

Date _____
DD MM YY

(Signature of Health Care Representative)