EM/ANB Inc.

Request for Access to Personal Health Information

(v.1, 2019)

Patient Information

Last Name: **First Name:**

Date of Birth (MM/DD/YYYY): **Medicare Number:**

Applicant Information

Title: **Last Name:** **First Name:**

Mailing Address:

Telephone #: **Fax #*:**

**Is this a secure fax number (not accessible to the public)?* Yes ☐ No ☐

E-mail Address:**

***Only provide if you wish to receive communications about your request via e-mail. Note: Personal Health Information will not normally be shared via e-mail.*

Check one (if not the patient, please provide proof that you are legally authorized to receive the information you are requesting):

☐ I am requesting my own personal health information

☐ I am the patient's Substitute Decision-Maker - includes parent/guardian for patient < 16 (attach proof)

☐ I am the patient's Legal/Personal representative (attach proof)

☐ I am the patient's HealthCare Provider Please specify: ____

☐ I am the Administrator/Executor of the patient's Estate (attach proof)
Please explain how the personal health information will be used for administration of the patient's estate, and attach any relevant proof:

☐ Other Please specify: ____

About Your Request

I hereby request access to the following personal health information (complete all that applies):

Ambulance New Brunswick patient record(s) ☐

Extra-Mural Program patient record ☐ Extra-Mural Unit: ____

Note: All requests will be reviewed and processed in accordance with the Personal Health Information Privacy and Access Act. If you have questions about the form or about how your request will be processed, please contact the Privacy & Information Access Officer at (506) 872-6594.

Time period for the information requested (from MM/DD/YYYY to MM/DD/YYYY **OR** specific date for single use of ambulance service): ____

I would like to (choose one):

☐ receive a hard copy of the record(s) ☐ review the record(s)

☐ receive an electronic copy of the record(s), if possible

If you would like to receive a copy of the record(s), please indicate where you would like them sent:

☐ Same address as above ☐ Fax number above

☐ Other address or fax number (please provide and indicate name of addressee, if different):

____

____ ______________________________
Signature* **Date**

**If you are not the patient, please provide proof that you are legally authorized to request and receive the patient's personal health information.*

If you are submitting your request in person, an employee will confirm your identity by checking a piece of ID and initialing here: Initials: ________

If you are not submitting your request in person, please have a witness complete the section below to attest that you are who you claim to be.

____ ______________________________
Print Witness Name **Telephone Number**

____ ______________________________
Witness Signature** **Date**

***By signing as a witness, you are attesting that the applicant is who s/he claims to be.*

Submitting your request:

Extra-Mural Program records: submit your request to the Manager of the applicable Extra-Mural Unit.

Ambulance New Brunswick requests: submit to the attention of the Privacy & Information Access Officer;

- in person or by mail to 210 John St., Suite 101, Moncton, NB, E1C 0B8
- fax: (506) 872-6509

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