PATIENT'S REQUEST FOR ACCESS TO PERSONAL INFORMATION

Upon request, we will give a patient (or the patient's legally authorized representative) access to his or her personal information from the records we have in our custody or that are under our control. Our privacy officer, _____, will also explain how we collect and use personal information, and to whom it has been disclosed.

Within 30 business days of receiving your completed "Request for Access to Personal Information" form (attached), we will provide you with a copy of the information, let you review the original records if we cannot reasonably provide copies to you, or give reasons for not providing access. We may extend the time for responding to your request in certain circumstances. We may also be permitted or required by law to refuse to give you access to some information in your records.

If we refuse access, our privacy officer will explain the reasons for this. If you disagree with our refusal, we will try to resolve the matter with you. If we cannot resolve the matter to your satisfaction, you may ask the College of Physicians and Surgeons of BC to try to resolve it. If you are still not satisfied, you may refer the matter to the Office of the Information and Privacy Commissioner for BC.

BC's Personal Information Protection Act allows us to charge you a minimal fee for access to your personal information. If we wish to charge a fee, we will provide you with a written estimate before we provide the service. We may require you to pay a deposit for all or part of the fee before we provide the service.

To request access to your personal information or information about a person you are legally authorized to represent, please complete the attached "Request for Access to Personal Information" form. If you need assistance, our privacy officer will help you complete the form.

The information on this form will be used to respond to your request for your personal information or the personal information of someone whom you are legally entitled to represent.

Patient's Information

Mr / Mrs / Ms (please circle)		Street Address	
Last Name		City/Town	
First Name		Province	
Personal Health Number		Postal Code	
Date of Birth (mm/dd/yy)		Tel (bus / cell / home)	
Email Address		Fax	

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Please describe, in as much detail as possible, the information you want to access. Indicate if you also want access to records about the disclosure of your information, or information of the person you are representing. Be sure to give previous names, if any.

Please indicate if you wish to:

☐ Receive a photocopy of the record.
Please note that a base fee of $_____ per page applies for each page copied. For convenience, you may enclose this fee with your request. You will be provided with an estimate of any additional costs.

☐ View the original record, without receiving a copy.
Please ask for an estimate of the fee you will be charged for:
- ☐ Review of the original by the physician ***and / or***
- ☐ Supervision by physician or designated staff person for your review

A deposit of 50% of the fee may be required.

Access by Patient

Patient Signature

Date (mm/dd/yy)

Access by Authorized Representative

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

Authorized Representative's Information

Mr / Mrs / Ms (please circle)		Street Address	
Last Name		City/Town	
First Name		Province	
Personal Health Number		Postal Code	
Date of Birth (mm/dd/yy)		Tel (bus / cell / home)	
Email Address		Fax	

Authorized Representative's Signature

Date (mm/dd/yy)