Alberta Health Services

Health Information Access Request
(Health Information Management)

Office Use Only
Patient HRN

Use this form to submit a request for your own health information or if you are requesting health information on behalf of a patient/client. Requests are usually processed within 30 days. Processing time may vary depending on complexity of the request and volume of records. **Fees are charged for processing a request for information. See reverse for instructions on completion and payment.**

Photo identification (ID) or two pieces of non-photo ID is required to confirm identity. If you are faxing or mailing in your request, please make sure photocopies are clear.

Patient/Client Information

Last Name	First Name
Birthdate *(yyyy-Mon-dd)*	Personal Health Number

Requester Information

Last Name ☐ Same as above	First Name ☐ Same as above
RECORDS DEPOSITION SERVICE, INC.	
Mailing Address: P.O. BOX 5054	

City/Town	Province	Postal Code	Phone
SOUTHFIELD	MICHIGAN	48086-5054	248-357-3330

Information Requested

Name and Location of Facility	Clinic/Program or Area of Service	Time Period of Records

Indicate the records or information you want *(attach a separate sheet of paper if you need more space)*

PLEASE SEE THE ATTACHED SUBPOENA OR LETTER REQUEST

☑ Mail information to the above address ☐ The information will be picked up *(ID required)*
Note: Information is held for 2 weeks then mailed

Authorization

If you are requesting on behalf of the patient/client, check the box below that applies to you and attach a copy of the document that confirms your authority to act on behalf of the patient/client. If submitting your request by the AHS website, you will be contacted to make arrangements to submit the supporting documentation.

- ☐ Guardian of an individual under the age of 18 years **AND** the individual is not a mature minor.
- ☐ Guardian or trustee appointed under the Adult Guardianship and Trusteeship Act, **AND** requested information relates to powers and duties of guardian or trustee.
- ☐ Nearest relative under the Mental Health Act **AND** requested information is needed to carry out obligations of the nearest relative.
- ☐ Agent under the Personal Directives Act **AND** directive has been enacted **AND** requested information is relevant to a decision the agent is authorized to make.
- ☐ Personal representative of a deceased patient/client and requested information relates to administration of the individual's estate.
- ☐ Power of attorney has been granted by the patient/client **AND** requested information relates to powers and duties of attorney.
- ☐ Written authorization has been given by the patient/client to make request on his/her behalf.

Requester Signature	Date *(yyyy-Mon-dd)*

Health information and personal information collected on this form will be used to process your request for health information. Collection of this information is authorized under section 20(b) of the Health Information Act and section 33(c) of the Freedom of Information and Protection of Privacy Act. AHS is collecting the personal health number under section 21(1) (a) of the Health Information Act. If you have questions about the collection of any information on this form please contact the AHS Health Information Management Access & Disclosure by phone at 780.735.0658.