Royal Victoria
Regional Health Centre

Hospital Unit #_____

Account # _____

OFFICE USE ONLY

REQUEST ACCESS TO PERSONAL HEALTH RECORDS

Information and Instructions:

- Please complete Parts A and B on this form
- Access will be provided, unless a legal exception applies
- Prepayment of applicable fees is required prior to releasing records

PART A: REQUESTER INFORMATION

Patient Information: (If under 16 years of age, parent or legal guardian must complete form)

Last Name _____ First Name _____ Initials _____

Mailing Address _____ City/Town _____ Postal Code _____

Telephone Number _____ Birth Date _____

Parent/Legal Guardian/Executor Information: (If applicable)
Note: Include copies of documents that provide your legal signing authority

Last Name _____ First Name _____ Initials _____

Mailing Address _____ City/Town _____ Postal Code _____

Telephone Number _____ Relationship to Patient _____

PART B: ACCESS REQUEST

Please let us know what information you need, including dates

- ☐ Report(s)
- ☐ Imaging
- ☐ Labs/Pathology
- ☐ Entire Visit
- ☐ Other/Date: _____

Signature _____ Name (Print) _____ Date _____

Witness _____ Name (Print) _____ Date _____

R.CONRA

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