BC Centre for Disease Control
An agency of the Provincial Health Services Authority

REQUEST FOR ACCESS TO HEALTH RECORDS

(CHECK SERVICE/CLINIC) ☐ TUBERCULOSIS (TB) SERVICES ☐ STI SERVICES ☐ DRUG & POISON INFORMATION CENTRE

PATIENT INFORMATION

LAST NAME	FIRST NAME	MIDDLE NAME	DATE OF BIRTH

STREET, APARTMENT NO., P.O. BOX, R.R. NO.	CITY / TOWN	PROVINCE / COUNTRY	POSTAL CODE

DAY PHONE NO. (REQUIRED) ( )	EMAIL ADDRESS (OPTIONAL)	FAX NO. (OPTIONAL) ( )

DETAILS OF REQUESTED INFORMATION

INFORMATION REQUESTED (PLEASE DESCRIBE THE RECORDS YOU ARE REQUESTING. BE AS SPECIFIC AS POSSIBLE AS THIS WILL ASSIST THE REQUEST PROCESS. ATTACH A SEPARATE SHEET IF THE SPACE BELOW IS NOT SUFFICIENT.	PLEASE SPECIFY ANY REFERENCE OR FILE NUMBER(S) IF KNOWN

ARE YOU REQUESTING ACCESS TO ANOTHER PERSON'S PERSONAL INFORMATION? ☐ YES ☐ NO
IF YES, PLEASE ATTACH, AS APPROPRIATE:
a) THAT PERSON'S SIGNED CONSENT FOR DISCLOSURE, OR
b) PROOF OF AUTHORITY TO ACT ON THAT PERSON'S BEHALF (i.e. authorizing letter)

TO ENSURE OUR COMMITMENT TO CLIENT PRIVACY, RECORDS REQUESTED VIA FAX OR MAIL MUST NORMALLY BE PICKED UP IN PERSON FROM A BCCDC CLINIC. PHOTO ID IS REQUIRED AT PICKUP FOR VERIFICATION PURPOSES.

PREFERRED METHOD OF ACCESS RECORDS	YOUR SIGNATURE	DATE SIGNED YR. MO. DAY
☐ EXAMINE ORIGINAL ☐ RECEIVE COPY		

FAX TO: TB SERVICES: 604-707-2690 | **STI SERVICES**: 604-707-5604 | **DRUG & POISON INFORMATION CENTRE**: 604-707-2807

MAIL TO: PRIVACY OFFICER, BC CENTRE FOR DISEASE CONTROL, #2112 – 655 WEST 12th AVE, VANCOUVER BC V5Z 4R4

YOU MAY MAKE A REQUEST FOR ACCESS TO RECORDS WITHOUT USING THIS FORM, PROVIDED YOU DO SO IN WRITING.
PERSONAL INFORMATION CONTAINED ON THIS FORM IS COLLECTED UNDER THE FREEDOM OF INFORMATION AND PROTECTION OF PRIVACY ACT AND WILL BE USED ONLY FOR THE PURPOSE OF RESPONDING TO YOUR REQUEST