Request to Access Health Information

Instructions:

- Use this form to submit a request for own health information or if you are requesting health information on behalf of someone else you have been authorized to act for.
- **An initial basic fee of $25.00 is required** before processing of your request will begin. Payment options appear on the next page.
- Please complete all sections of this form and return by mail (address provided on next page), by email records@casaservices.org or by fax to 780-437-6133.
- Photo identification or two pieces of government issued non-photo ID are required to confirm identity. If you are faxing or mailing in your request, please make sure photocopies of your identification are clear and legible.

Requester Information:

Last Name:	First Name:		
Organization: (if applicable)			
Address:	City:	Province:	Postal Code:
Email:	Phone:	Fax:	

Complete this section when you are requesting someone else's health information.
With your request, you must include proof that you can legally act for that individual (in accordance with Section 104 of the Health Information Act).

Full Name:	Date of Birth: (dd-mmm-yyyy)
Health Care Number:	Relationship to Requester:

Records Requested:

What records do you want to access? Be as specific as possible to aid us in your request.
☐ Assessment (e.g., psychological, psychoeducational) ☐ Discharge Summary
☐ Other (e.g., medication, diagnosis) specify: _____

Purpose:
☐ For a medical appointment ☐ Application for benefits
☐ Other: _____

Time period of records:
From: (dd-mmm-yyyy) _____ To: (dd-mmm-yyyy) _____

I wish to receive the information via:
☐ Secure email (no charge) ☐ Courier or registered mail (charges apply)
☐ Picking it up in person at any CASA site (no charge)

Signature:	Date: (dd-mmm-yyyy)

CASA Mental Health (CASA) protects the privacy of individuals in accordance with the *Health Information Act (HIA)*. Personal and/or health information collected on this form will only be used for the purpose of responding to the request and is collected pursuant to section 20(b) of the HIA. Collection will occur directly from the individual except in specific circumstances in accordance with section 22(2)(b). CASA is collecting the personal health number in accordance with section 21(1)(a). For more information or if you have any questions about the collection of this information, please contact CASA's Privacy Office by email at privacy@casaservices.org or by phone at 780-400-2271.

How to Complete the Form

Completing the Request Form:

1. **Requester/Contact Information:** Reference the full name, date of birth, and personal health number of the individual for whom information is being requested. Ensure your complete mailing address and current contact information is included as our office may need to contact you if they have any questions about your request.

2. **Patient/Client Information:** When making any request for health information you will have to provide proof of your identity. If you are requesting records for another person, in addition to providing proof of your identity, you will have to provide proof that you have the authority to act for that person. For example, you may provide proof that you are their legal guardian or trustee, or that you have power of attorney. Ensure you include legible copies of any and all supporting legal documentation (up to and including the most recent).

3. **Types of records requested:** What health records are you requesting? Please be as specific as possible in describing the records. If you need more space, please continue your description on a separate sheet of paper and attach it to this request form.

4. **The purpose of the request:** Indicate for what purpose the records are being requested.

5. **Time period:** For example, if you are requesting records pertaining to specific services received sometime between the periods of January 1, 2000 to August 31, 2000, enter those dates in the space provided. If you are unsure, approximations are still appreciated.

6. **Mode of access:** Indicate how you would like to receive the information. Charges do apply for courier or registered mail.

7. **Signature:** Please ensure you have signed and dated the form.

8. **Fees:** Payment for fees can be made by electronic transfer, VISA or MasterCard, or by cheque/money order.

To pay by electronic transfer please send payment to accounts.receivable@casaservices.org and indicate the payment is for Health Records within the message text box (if you are paying the basic fee of $25.00).

To pay by cheque or money order, please mail the completed form along with your payment to the mailing address below. Please make payments payable to: CASA Mental Health. Please reference Health Records on the memo line.

To pay by credit card, go to this website: http://weblink.donorperfect.com/CASA_HealthRecords or use the scan feature on your mobile device to use the QR Code below.

CASA Mental Health Contact Information
Phone Number: 780-400-2271 **Fax Number:** 780-437-6133
Mailing Address: 10645 63 Ave, Edmonton, AB T6H 1P7