REQUEST A COPY OF SOMEONE ELSE'S HEALTH RECORDS

Please mail, email or fax your completed form to the applicable Health Records location

PLEASE USE FORM REQ-1 IF YOU ARE REQUESTING YOUR OWN HEALTH RECORDS

Part 1 – Requestor Information *(your own information)*

Last Name	First Name		
Organization Name if applicable (e.g., Law firm)		Phone Number *(during business hours)*	
Mailing Address *(where records will be mailed)*	City	Province	Postal Code

SEND RECORDS BY: ☐ **MAIL** **or** ☐ **ENCRYPTED EMAIL – must provide email address:**

Part 2 - Patient Information *(information about the patient whose records you are requesting)*

Last Name	First Name, Middle Name(s)	Personal Health Number (*Care Card Number*)	
Former Name(s)	Date of Birth (yyyy-mmm-dd)	Date of Death, if applicable (yyyy-mmm-dd)	
Last Known Address	City	Province	Postal Code

Part 3 – Records Requested

3.1 Specify the Island Health facility you are requesting records from

- For a list of Island Health facilities, please visit https://www.islandhealth.ca/our-locations. Be as specific as possible as this will help us process your request faster.
- Listing "all" sites will result in searches taking place at locations where you have not received services and will lead to delays in processing your request.

3.2 Identify the services you accessed at Island Health from which you are requesting records.

☐	Inpatient (hospital stays)	☐	Community Urgent Care Centers	☐	Seniors Outreach Programs
☐	Ambulatory Clinics	☐	Primary Care Centers	☐	Other Services (describe below)
☐	Daycare (medical or surgical)	☐	Home & Community Care		
☐	Emergency Department	☐	Residential Care Facilities		
☐	Diagnostic (e.g., lab, imaging)	☐	Outpt Mental Health & Substance Use Svcs (MHSU)		
☐	Public Health	☐	Development Disability Mental Hlth Team (DDMHT)		

3.3 Identify the types of records that you are requesting below

- Please be advised, larger requests will result in extensions to the due date of this request as per FOIPPA due to the amount of time it will take to gather, copy and process the records. In order to provide a timely response please be as specific as possible in identifying the records you require.

Limited Scope Records Request	☐ Lab Results	Medical Imaging:	☐ Reports	☐ CD	☐ Other (describe)

☐ **Standard Records Package** – This type of request will not produce all records in our system but will produce the most commonly sought after records such as progress notes, clinic notes, specialist consultation reports, operative/procedural reports, discharge summaries, history and physicals, lab and medical imaging results and emergency department records. This package does not include notes from nursing or allied health professionals.

☐ **Other Specified Records in a Date Range** – Other records not identified in the Standard Records Package. Provide specific details of the records you require. This type of request will produce records able to be located based on the information that you have provided. Please note that these types of requests typically result in extensions due to the large volume of searching and copying required. If you select this option, ensure that you provide the **specific locations** you have received services at in section 2.1 above.

Description of additional records required:

3.4 Date Range of Records Requested: If you do not know exact dates, please provide best estimate	Date From (yyyy-mmm-dd)	Date To (yyyy-mmm-dd)

Part 4 – Patient Consent *(age 12 or older)*

I consent to the release of my records identified in PART 3 (Records Requested) of this form to the individual/organization identified in PART 1 (Requestor Information) of this form:

Patient Name (Print)	**Patient Signature**	**Date Signed (yyyy-mmm-dd)**

If you are requesting records without patient consent, please complete Parts 5 to 7 on the next page

Part 5 – Purpose of Request	Describe the purpose of your request and how you are acting on behalf of the person you are requesting records for. Attach additional pages if necessary.

Part 6 – Who may act on behalf of a Person

Please select or provide **one** situation from category A through E below that best describes in what capacity you are acting on behalf of a person in relation to the purpose of your request described in PART 5.

A) Who may act on behalf of an Adult

- ☐ I am the **Committee of Person**
- ☐ I am the **Litigation Guardian**
- ☐ I am the **Representative** under the *Representation Agreement Act*
- ☐ I am the **Power of Attorney** (*see limits to records access below*)

B) Who may act on behalf of a Minor *(age 11 or younger)*

- ☐ I am **Guardian** under a court order or legal agreement
- ☐ I am **Guardian** as I am the parent who has lived with or regularly cared for this minor and there is no order or agreement removing my guardianship

C) Who may act on behalf of a Deceased Adult

- ☐ I am the **Executor** or **Administrator of Estate**
- ☐ I am the **Committee of Person/Estate**

If there is no Executor, Administrator of Estate, or Committee of Person, appointed by court order, then the appropriate person falls to the nearest relative who is the first person in the following list who is willing and able to act on behalf of the deceased.

I am the:
- ☐ **Spouse**
- ☐ **Adult Child**
- ☐ **Parent**
- ☐ **Adult Brother** or **Sister**
- ☐ **Other Adult Relation** (describe below)

D) Who may act on behalf of a Deceased Minor *(under 19)*

- ☐ I am **Executor** or **Administrator of Estate**
- ☐ I am **Guardian** under a court order or legal agreement
- ☐ I am **Guardian** as I am the parent who lived with or regularly cared for this minor and there is no order or agreement removing my guardianship

If there is no Executor, Administrator of Estate, or Guardian, then the appropriate person falls to the nearest relative who is the first person in the following list who is willing and able to act on behalf of the deceased.

I am the:
- ☐ **Parent** (but not guardian)
- ☐ **Adult Brother** or **Sister**
- ☐ **Other Adult Relation** (describe below)

E) Other Adult Relationship to patient/deceased (attach additional pages or records if necessary)

IMPORTANT INFORMATION *– You are required to submit legal documentation for the selection that you have made in sections A through E in Part 6 above. For example, if you are the executor for the patient, you must submit the pages of the Will, which show you as the executor to the Will, as well as the pages showing that the Will has been signed and executed. If there are multiple executors who must act jointly to a Will, all executors will be required to sign this request. If you are requesting information for a minor who is age 12 or older, the minor must sign the Patient Consent in Part 4 of this form.* ***Island Health is only authorized to release records necessary to support the scope of the duties or powers granted to you and limited to your stated purpose. Access to records that are not necessary to support your granted duties, powers and stated purpose will not be provided.***

Part 7 – Requestor Attestation

I attest that I have the legal authority to act on behalf of the patient and that the information I have provided is truthful and accurate.

Requestor Name (Print)	**Requestor Signature**	**Date Signed (yyyy-mmm-dd)**
Co-Requestor Name (If Applicable)	**Co-Requestor Signature (If Applicable)**	**Date Signed (yyyy-mmm-dd)**

Send your completed form to the Health Records location you are seeking records from

Find a list of Health Records locations under "FOI Officers Contact List" on our public website:

https://www.islandhealth.ca/about-us/accountability/information-stewardship-access-privacy/accessing-information-records

Please note the following:

- Requests for health records are typically processed within 30 business days, which is about 43 calendar days. Some requests may take longer due to volume of records, extent of search time, or if insufficient detail has been provided in your request.
- You may be required to provide further proof of identity prior to release of any records such as government photo id. It is Island Health policy to forward requests believed to be fraudulent to the police.
- Please be advised that Island Health is not obliged to provide copies of records that have been previously provided.

Island Health Internal Use Only	
REQUEST #	*DATE RECEIVED BY ISLAND HEALTH*