

Request for Access to Personal Health Information in the eHR Viewer

I, the undersigned, understand that the eHR Viewer is a secure system that provides access to patient profiles regardless of where an individual presents for care or where they live in the province, and that this system is used by authorized health care professionals to make decisions about health care treatments for me, and that copies of my information in the eHR Viewer will be provided to me upon request.

I request copies of my personal health information available in the eHR Viewer between _____ to _____ for the following information:

- Laboratory Results
- Prescription Profile
- Clinical Documents (ex. Discharge Summary, Radiology Reports)
- Clinical Encounters
- Immunization Profile
- Chronic Disease Management Observations

Personal health information on this form is collected under the authority of *The Health Information Protection Act* (HIPA). This information will only be used to ensure accuracy, and to generate (an) access report(s). Specifically, the Health Services Number will be used to confirm identity, and authenticate this request in order to protect confidentiality. Personal health information is protected from unauthorized use and disclosure in accordance with HIPA, and may only be collected, used and disclosed as provided in HIPA.

Please fill out the section below:

_____ Printed Name of Applicant	_____ Health Services Number of Applicant
_____ Date of Birth of Applicant (yyyy-Mon-dd)	_____ Phone Number (During business hours)
_____ Address of Applicant	_____ Province
_____ Postal Code	
Specify how you would like your information sent to you (if files are very large they will be sent by mail):	
<input type="checkbox"/> Mail: Address (if different from above): _____ _____	
<input type="checkbox"/> Email:* _____ _____	
<small>* E-mail transmissions cannot be guaranteed to be secure or error free as emails can be intercepted, corrupted, destroyed, arrive late or incomplete, or contain viruses</small>	
_____ Signature of Applicant	_____ Date Signed by Applicant (yyyy-Mon-dd)

If you are signing as an Agent for the Applicant, please include evidence of your authority to act as Agent.

_____	_____
Printed Name of Agent	Phone Number (<i>During business hours</i>)
_____	_____
Signature of Agent	Date Signed by Agent (<i>yyyy-Mon-dd</i>)

Please submit both pages of this completed form to:

Mail: eHealth Privacy Service

Suite 101 - 1901 Scarth Street

Regina, SK

S4P 2H1

Email: privacyandaccess@eHealthSask.ca

Please note that original copies and legible fax copies or document scans will be accepted.

More information about privacy and eHealth programs can be found at: www.eHealthSask.ca