Request for Access/Correction(s) to Personal Health Information (ON & BC)

LIFELABS STAFF USE ONLY

Please check this box if you have verified attached photo ID: ☐

For British Columbia patient requests, please forward form to Admin. Support - VRL

Note: if this is request for CORRECTIONS, please forward it to Privacy Office

Patient label below

FORM INSTRUCTIONS:

- **ACCESS REQUEST FILL OUT SECTION A**
- **CORRECTIONS REQUEST FILL OUT SECTION B**

- **Please attach a clear copy of your photo identification with this form such as: health card with your photo, driver's license, Canadian Citizenship and/or passport**
- **Fees: Our Customer Service Centre Representative will contact you to provide you with the associated fee estimate**

If you have any questions concerning this form, please contact our Privacy Office at: 1-844 - 783 – 6677

SECTION A:

REQUEST FOR ACCEESS TO PERSONAL HEALTH INFORMATION

Client Information (please print clearly)

Name: _____ Health Card Number: _____

Address: _____ Phone Number: ( ) - _____ Date of Birth: _____
DD/MM/YYYY

Signature: _____ **Date:** _____

DESCRIBE THE HEALTH INFORMATION YOU WANT ACCESS TO

Please describe your personal health information you are requesting to receive hardcopies of including dates of service:

_____

Date(s) of Service: _____
DD/MM/YYYY

Authorized Representative (if applicable)

If you are signing on behalf of the client, please state your relationship

I _____, am **Relationship to the client:** _____
Name of Representative (print clearly)

Signature: _____ **Date:** _____
DD/MM/YYYY

SECTION B

REQUEST FOR CORRECTION(S) TO PERSONAL HEALTH INFORMATION

Client Information (please print clearly)

Name: _____ Health Card Number: _____

Address: _____ Phone Number: ( ) - _____ Date of Birth: _____
DD/MM/YYYY

Signature: _____ **Date:** _____

Please describe what you want corrected and include date(s) of service

_____

_____

Authorized Representative (if applicable)

If you are signing on behalf of the client, please state your relationship

I _____, am **Relationship to the client:** _____
Name of Representative (print clearly)

Signature: _____ **Date:** _____
DD/MM/YYYY

Please mail the completed form to:

ONTARIO (access requests)	**BRITISH COLUMBIA (patient requests)**
Customer Care Centre - KRL **6560 Kennedy Road** **Mississauga, ON** **L5T 2X4**	**Admin. Support – VRL** **3201-4464 Markham St** **Victoria, BC** **V8Z 7X8**