Alberta Health Services

Intake Site	
Patient/Client Name *(last name, first name)*	
HRN	Gender
PHN	Birthdate *(yyyy-Mon-dd)*

Health Care Provider Request for Use and Disclosure of Health Information

This form is to be used only when the information is required for continuing care purposes and

- **if the information is not available in Netcare, or**
- **if the requestor does not have access to Netcare.**

Complete this form and forward both pages to the applicable Health Information Management department. If records are not managed by Health Information Management, forward to the applicable department.

Intake Information

Request Taken By *(last name, first name)*	Intake Date *(yyyy-Mon-dd)*	Intake Time *(hh:mm)*
Date of Patient/Client Last Visit *(yyyy-Mon-dd)*	Chart Location	

Urgency Category

☐ Date Required *(yyyy-Mon-dd)* _____ ☐ Time Required *(hh:mm)* _____ ☐ STAT

Requestor Information

Name of Requesting Care Provider	Name of Clinic or Business	City/Town
Name of Contact Person ☐*Same as Requesting Care Provider*	Phone *(nnn-nnn-nnnn)* ☐*Confirmed long distance*	

Method of Disclosure

☐	Fax ▶	Number ☐*Confirmed long distance*	☐ Fax Number Verified Name of person that verified ☐*Same as Intake* *(print last, first name)* _____		
☐	Canada Post ▶	Mailing Address	City/Town	Province	Postal Code
☐	Courier/TransMed ▶	Physical Address ☐*Same as Mailing*	City/Town	Province	Postal Code
☐	Interoffice Mail ▶	Room #	Unit	Floor	Site
☐	Verbal ▶	Information Disclosed			

Personal information on this form is collected under section 20 of the Health Information Act. Alberta Health Services is collecting the personal health number as a custodian under Section 21(1) of the Health Information Act. If you have questions about the collection and use of any information on this form contact the Disclosure Help Line at 1.855.312.2265.

Alberta Health Services

Patient/Client Name *(last name, first name)*
HRN

Health Care Provider Request for Use and Disclosure of Health Information

	Documents Requested	**Date of treatment** *(yyyy-Mon-dd)*
☐	Cardiac Diagnostics ☐ Cardiac Cath ☐ ECG ☐ Echo ☐ Holter ☐ Myocardial Perfusion ☐ Treadmill/Stress	
☐	Consults	
☐	☐ Delivery Note ☐ Delivery Record ☐ Notice of Birth ☐ Prenatal	
☐	Diagnostic Imaging ☐ CT Scan ☐ MRI ☐ Ultrasound ☐ Xray	
☐	Discharge Summary	
☐	Emergency/Urgent Care Record ☐ Emergency Assessment Record	
☐	History & Physical	
☐	Immunizations	
☐	☐ Laboratory ☐ Pathology	
☐	Medication Administration Record	
☐	Operative Report *(specify type)* _____ ☐ Anesthetic Report ☐ Post-Anesthetic Report	
☐	☐ Psychology Notes ☐ Psychiatric Notes	
☐	Rehab Notes ☐ Occupational ☐ Physio ☐ Speech	
☐	Social Work Notes	
☐	Other *(specify)* _____	
	_____	
	_____	
	_____	
	_____	

To be completed by office responding to the request. Return a copy of this form to the requestor with documents disclosed.

Complete a Notice to Recipient of Health Information *(form 18027)* and forward to requestor when disclosing information under section 35(1) (b) or (e) of HIA.

Comments	**Signature**	**Date** *(yyyy-Mon-dd)*

Total Pages Disclosed *(excluding request and fax cover sheet)*

Request Completed by *(print last, first name)*	Signature	Date *(yyyy-Mon-dd)*

Clear All Content