APPENDIX 1

Health Information Act Forms

1. Request to Access Health Information
2. Authorization of Representative and Affidavit for Witness
3. Access Request Review Form
4. Access Request Recommendation Form
5. Request to Correct or Amend Health Information
6. Sample Collection Notice (Section 22(3))
7. Consent to Disclosure (Section 34)
8. Notice to Non-Custodian (Section 32(2))
9. Notice to Recipient (Disclosure with Consent)
10. Notice to Recipient (Disclosure without Consent)
11. Components for an Affiliates Oath of Confidentiality
12. Request for Review (Office of the Information and Privacy Commissioner)

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Request to Access Health Information

The information on this form is collected under Alberta's *Health Information Act* and will be used to respond to your request for your own health information. Instructions for completing this form are on the back.

☐ Mr. ☐ Ms ☐ Dr. ☐ Mrs. ☐ Miss	Last name	First name
Mailing address		
City or town	Province	Postal code

Telephone (business) ( )	Telephone (home) ( )	Fax number ( )	E-mail address
Date of Birth (day) (month) (year)	Other		

1. Please attach the initial fee of $25.00.
2. To which custodian are you making your request? *(Please fill in the name of the individual or organization.)*

3. Do you want to: (a) receive a copy of the record? **OR** (b) examine the record?

1. What records do you want to access? Please give as much detail as possible. Indicate if you also want access to records about the disclosure of your information. *(Be sure to give all your previous names. If you are requesting access to another individual's information, you must include information to identify the individual (in the box below) and attach proof that you can legally act for that individual (under section 104 of the Act). If you need more space, please attach a separate sheet of paper.)*

2. What is the time period of the records? Please give specific dates. *(See reverse for details.)*

Signature	Date

For authorized office use only:

Date received	Request number

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How to complete the form

You may be able to access your own health information without making a request under the *Health Information Act*. To determine whether you need to make a request under the *Act* or if you need help completing the form, contact the HIA Coordinator or the person responsible for processing requests in the organization to whom you are making the request.

About you

Check the title by which you prefer to be addressed and enter your last name and first name. Enter your complete mailing address and your daytime and evening telephone numbers. The custodian may need to contact you if they have any questions about your request. If you have a fax number or E-mail address where correspondence can be sent, enter them in the spaces provided.

About your request

If you need help to find out what records a custodian has, please consult their HIA Coordinator or the person responsible for processing requests.

1. If you are making a request for your own health information you will have to provide proof of your identity before the records are released to you. If you are requesting records for another person, you will have to provide proof that you have the authority to act for that person. For example, you might provide proof that you are the person's guardian or trustee or that you have power of attorney for the person. There will be an initial fee of $25. If additional fees are charged, you will be provided with an estimate of how much your request will cost before processing begins. Processing starts once you have paid at least 50% of any estimated fee. The records are provided when the fee is paid in full.

2. Enter the name of the custodian that you believe has the records that you want to access.

3. Do you want to receive a copy of the record or examine the record? Check the appropriate box.

About the information you want to access

1. What health information are you requesting? Please be as specific as possible in describing the records. The more specific your request, the quicker and more accurately it can be answered. If you need more space, please continue your description on a separate sheet of paper and attach it to this request form.

   Please be sure that you give:
   - your full name;
   - any other names that you have previously used; and
   - any identifying number that relates to the records, such as your personal health number, case number or other identification number.

   If you are requesting records for another person, you will have to provide proof that you have the authority to act for that person.

2. Enter the time period of the requested records. For example, if you are requesting records for the period January 1, 1998 to August 31, 1999, enter those dates in the space provided. If you want records from August, 1996 to the present, enter "August, 1996 to the present."

Your signature

Sign and date the form and send it to the HIA Coordinator or person responsible for processing requests. If you are not sure of where to send the form, please consult the HIA Coordinator or other responsible person of the organization that has the records you wish to access.

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Authorization of Representative
(Under Section 104(1)(i))

I, ______________________________________ living at ______________________________________ ,

(name of municipality), in the province of ___________________________________,

designate ____

living at ______________________________________ (name of municipality) in the province of

______________________________ as my authorized representative to act on my behalf,

and to exercise (check one of the following):

☐ all my rights under the *Health Information Act;* OR

☐ my right to access all records containing my health information; OR

☐ other – define:

____

____

____

☐ the rights that are conferred on me under the *Health Information Act* in regard to the following questions:

____

____

I confirm that my representative has the authority to carry out the above rights and responsibilities on my behalf.

The present authorization will be in effect until _________________________ 20_____

SIGNED BY _____________________________________ in the presence of:

____

Witness

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Affidavit for Witness (Optional)

Canada
in the Province of Alberta

I, ____________________, ______________________ of _______________________
(name of the witness in full) (occupation of witness) (complete home address of witness)

in the province of ___________________________________, make oath and say that:

1. I was personally present and I saw _______________________________ sign the
(name of person)
Authorization of Representative to which this is attached.

2. The Authorization of Representative was signed by _______________________
(name of the person)
At ____ in the province of

________________________ and that I am the one who witnessed the document.

3. I know ____________________ and I believe that he/she is 18 years of age or older.
(name of person)

____
Signature of Witness

Sworn before me at _______________________

in the province of _________________________

on _____________________________________

____
Commissioner for Oaths

____
(print name here)

My Commission expires ________________, 20________

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HEALTH INFORMATION ACT

ACCESS REQUEST REVIEW

NAME OF CUSTODIAN

Where are the Records Held?	**Request No.:**

PART 1 - GENERAL

METHOD OF ACCESS REQUESTED

☐ Examine Originals ☐ Copies (selected documents) ☐ Copies (all) ☐ Other (specify):_______________

TRACKING DATES

Date Received	Request Due Date	Revised Due Date	Request Closed Date

AREA(S) ASSIGNED TO PROCESS REQUEST

SUMMARY OF STAFF TIME SPENT ON REQUEST

Locate Records	Review Records	Sever Records	Prepare Response Pkg.	Name(s)	Total Hours Spent (min. ¼ hour)
☐	☐	☐	☐	___	___
☐	☐	☐	☐	___	___
☐	☐	☐	☐	___	___
☐	☐	☐	☐	___	___

SUMMARY OF RECOMMENDATIONS FROM HIA COORDINATOR

(Attach a separate sheet if the space below is not sufficient.)

Prepared by: (type name and sign**)**	**Approved by:** (type name and sign) **HIA Coordinator or Responsible Affiliate**
Title:	**Date:**

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ACCESS REQUEST REVIEW - PAGE 2

NAME OF CUSTODIAN:	Request No.:

PART 2: RETRIEVAL AND REVIEW OF RECORDS

Area Where Records Located:	Contact Person:	Telephone No.:

LOCATION AND RETRIEVAL OF RECORDS

Search Done By: (name in print)	Start Date:	Target Completion Date:	Actual Completion Date:

Areas Searched (attach file lists, indices or other aids used in search):

Records Retrieved (by title - use attachment if necessary):

REVIEW OF RECORDS BY AREA HOLDING RECORDS

Records Reviewed By: (name in print)	Start Date:	Target Completion Date:	Actual Completion Date:

SUMMARY OF RECOMMENDATIONS FROM AREA HOLDING RECORDS

Approved By: (type name and sign)
Date:

ACCESS REQUEST RECOMMENDATION

NAME OF CUSTODIAN

<table>
<tr><td colspan="3">Where are the Records Held?</td><td colspan="2">Request No.:</td></tr>
<tr><td colspan="3">To:</td><td colspan="2">Date:</td></tr>
<tr><td colspan="3">From:</td><td colspan="2">Name of Applicant:</td></tr>
<tr><td colspan="3">Records / Information Requested:</td><td colspan="2">Number of Files / Pages Reviewed:</td></tr>
<tr><td colspan="5">Types of Health Information Contained in the Records:</td></tr>
<tr><td colspan="5">Exceptions Recommended:</td></tr>
<tr><td colspan="5">Application of Discretionary Exceptions (summarize reasons):</td></tr>
<tr><td colspan="5">Application of Mandatory Exceptions (summarize reasons):</td></tr>
<tr><td colspan="5">Severing Required (summarize reasons):</td></tr>
<tr><td colspan="2">Prepared by:
(signature)</td><td colspan="3">Approved by:
(signature)</td></tr>
<tr><td>Title:</td><td>Date:</td><td colspan="2">Title:</td><td>Date:</td></tr>
</table>

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NAME OF CUSTODIAN

ACCESS REQUEST RECOMMENDATION: DETAILED REVIEW OF RECORDS

(use multiple sheets if necessary)

Request No.:		Name of Custodian:	Area Holding Records:		Contact Person:	Telephone No.:
Document No.	**No. of Pages**	**Document Date**	**Document Description**	**Exceptions Applied (Section #'s)**	**Comments / Explanations**	**Consultation (Yes or No)**

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Request to Correct or Amend Health Information

The information on this form is collected under Alberta's *Health Information Act* and will be used to respond to your request for correction or amendment. Instructions for completing this form are on the back.

☐ Mr. ☐ Ms ☐ Dr. ☐Mrs. ☐ Miss	Last name	First name
Mailing address		
City or town	Province	Postal code

Telephone (business) ( )	Telephone (home) ( )	Fax number ( )	E-mail address
Date of Birth (day) (month) (year)	Other		

1. Whose information do you want to correct?

   ☐ Your own health information

   ☐ Another person's health information *(Please include information to identify the other individual and attach proof that you can legally act for the individual (section 104 of the Act)*

2. To which custodian are you making your request? *(Please fill in the name of the individual or organization.)*

3. What health information needs to be corrected or amended? Please give as much detail as possible. *(Be sure to give the complete name that is in the records if it is different from the name given above. If you need more space, please attach a separate sheet of paper.)*

4. What correction or amendment do you want to make and why? *(Please attach any documents that support your request.)*

Signature	Date

For authorized office use only:

Date received	Request number

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How to complete the form

You can correct or amend information in many custodian records without making a request under the *Health Information Act*. To determine whether you need to make a request under the *Act* or if you need help completing the form, contact the HIA Coordinator or the person responsible for processing requests in the organization to whom you are making the request.

About you

Check the title by which you prefer to be addressed and enter your last name and first name. Enter your complete mailing address and your daytime and evening telephone numbers. The custodian may need to contact you if they have any questions about your request. If you have a fax number or E-mail address where correspondence can be sent, enter them in the spaces provided.

About your request

1. Whose information do you want to correct or amend? Indicate whether you want your health information or another person's health information to be corrected.

   Your health information: If you want your records to be corrected or amended, you will have to provide proof of your identity.

   Another person's health information: If you want the records of another person to be corrected or amended, you will have to provide proof that you have the authority to act for that person. For example, you might provide proof that you are the person's guardian or trustee or that you have power of attorney for the person.

2. Enter the name of the custodian that you believe has the records that you want to correct or amend.

About the information you want to correct

1. What records contain the information that you want corrected or amended? Please be as specific as possible in describing the records. The more specific your request, the quicker and more accurately it can be answered. If you need more space, please continue your description on a separate sheet of paper and attach it to this request form.

   If you want a correction or amendment made to your own health information, please be sure that you give:
   - your full name;
   - any other names that you have used on the records; and
   - any identifying number that relates to the records, such as your personal health number, case number or other identification number.

   If you want a correction made to another person's information, please give:
   - the person's full name;
   - any other name that person may have used on the records; and
   - any identifying numbers (such as a personal health number, case number, etc.) for the person if you know them.

2. What corrections or amendments do you want made? What is incorrect about the information that is currently on the record? Please be specific.

Your signature

Sign and date the application and send it to the HIA Coordinator or personal responsible for processing requests in the appropriate organization. If you are not sure of where to send the form, please consult the HIA Coordinator or responsible person in the organization that has the records you wish to correct or amend.

SAMPLE COLLECTION NOTICE (SECTION 22(3))

For the purposes of section 22(3), a collection notice may be:

explained orally to individuals;
added to the top of a questionnaire or application form;
put in a publication (e.g. brochure) or other information about a program or service and provided to individuals;
put in a poster on a physician's office or pharmacy wall; or
put in a pop-up screen as part of a computer program

An example of a collection notice is as follows:

"The health information that we are collecting is needed to determine your eligibility for the ______________ program, service or benefit (or to provide you with diagnostic, treatment and care services) (or for the training of students) (or for research or statistical purposes) (or for other authorized purpose(s) under section 27 of the *Health Information Act*). It is collected under the authority of the (Mental Health Act) (or Cancer Programs Act) (or Hospitals Act) (or Nursing Homes Act) (or Alberta Health Care Insurance Act) (and/or section 20(b) of the *Health Information Act* – directly related to and necessary to carry out an authorized purpose under section 27) (or other legal authority). The confidentiality of this health information and your privacy are protected by the provisions of the *Health Information Act* (and any other act that is appropriate to add).

If you have any questions about this collection and use of your health information, please talk to one of the staff (or contact) ____________ (position) at ___________ (business address) or phone ____________ (business phone)."

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CONSENT TO THE DISCLOSURE OF INDIVIDUALLY IDENTIFYING HEALTH INFORMATION

AUTHORIZED BY THE HEALTH INFORMATION ACT (*HIA*), SECTION 34

CLIENT INFORMATION:

Name: ____
(surname) (given name/names)

Date of Birth: ______________________
(day/month/year)

Address: ____

I authorize my individually identifying health information related to ___________________

____
(description of information/relevant dates, etc)

to be disclosed by ____
(name of custodian)
in accordance with section 34 of the *Health Information Act* to,

____
(name of recipient)
for the following purpose(s): ____

____

I understand why I have been asked to disclose my individually identifying information, and am aware of the risks or benefits of consenting, or refusing to consent, to the disclosure of my individually identifying information. I understand that I may revoke this consent in writing at any time.

Dated this _______ of ________, ______. Expiry date: _____ of _______, ______
(day) (month) (year) (day) (month) (year)

____
Signature of client/authorized representative*

* if you are signing on behalf of the client, the following information must be provided:

____
Print Name of Authorized Representative

____
Print Source of Representative's Authority [refer to *HIA* section 104(1)]

____
Witness Signature

____
Witness Name

SECTION 32(2) NOTICE TO ACCOMPANY THE DISCLOSURE OF NON-IDENTIFYING HEALTH INFORMATION TO A RECIPIENT THAT IS NOT A CUSTODIAN

TO: ____________________________________ (Name of Recipient)

If you intend to use the attached non-identifying health information for data matching, you must notify the Information and Privacy Commissioner (780-422-6860). The *Health Information Act* defines data matching to mean the creation of individually identifying health information by combining individually identifying or non-identifying health information or other information from two or more electronic databases, without the consent of the individuals who are the subjects of the information. Failure to notify the Commissioner of the intention to data match is an offence under the *Act* and may result in a fine of up to $50,000.

____________________________________ ________________________

Name and Signature of Custodian (or affiliate) Date

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SECTION 42 NOTICE TO RECIPIENT TO ACCOMPANY THE DISCLOSURE OF INDIVIDUALLY IDENTIFYING DIAGNOSTIC, TREATMENT AND CARE INFORMATION BY A CUSTODIAN

Disclosure with the Subject's Consent

The attached individually identifying diagnostic, treatment and care information of
_______________________________________ (subject of information) is being disclosed to
_______________________________________ (name of recipient) by
____ (name of custodian) on
______________________________ (date), with the consent of
____________________________(name of the subject) under section 34 of the *Health Information Act,* only for the following purpose (s):

____
____
____
____
____
____
____

______________________________________ ________________________

Name and Signature of Custodian (or affiliate) Date

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SECTION 42 NOTICE TO RECIPIENT TO ACCOMPANY THE DISCLOSURE OF INDIVIDUALLY IDENTIFYING DIAGNOSTIC, TREATMENT AND CARE INFORMATION BY A CUSTODIAN

Disclosure Without the Subject's Consent:

The attached individually identifying diagnostic, treatment and care information of ________________ (named individual subject) has been disclosed to ___________________ (name of recipient) by ______________________ (name of custodian) on _________ (date), without the consent of the subject, but authorized under the following provision of the *Health Information Act* (mark the appropriate box)

- ☐ To provide information to another government (federal/provincial/territorial) when the above individual received a health service in Alberta which is paid for by that government ((s.35(1)(a.1))
- ☐ To provide continuing treatment and care to the above individual (s.35(1)(b))
- ☐ To provide information concerning the presence, location, condition, diagnosis, progress and prognosis of the above individual on the above date and the above individual has not requested otherwise (s.35(1)(c)) (Note – recipient must be a family member or another person with whom the individual is believed to have a close personal relationship)
- ☐ To advise family members of the above individual, or a person with whom the above individual is believed to have a close personal relationship, that the individual has been injured, is ill or has died and the individual has not requested otherwise (s.35(1)d))
- ☐ To advise family members of the above deceased individual, or a person with whom the above deceased individual is believed to have a close personal relationship, the circumstances surrounding the death of the individual or the health services recently received by the individual and the individual had not requested otherwise (s.35(1)(d.1))
- ☐ To provide health services to the above individual who is being detained in a penal or other custodial facility (s.35(1)(e))
- ☐ To conduct an audit of the information (s.35(1)(f)) (Note – recipient must enter into an agreement with the custodian about non-disclosure and destruction of the information)
- ☐ To carry out quality assurance activities within the meaning of section 9 of the Alberta Evidence Act (s.35(1)(g))
- ☐ To provide information for a court proceeding or a proceeding before a quasi-judicial body (s.35(1)(h) (Note – the custodian must be a party to the proceeding)
- ☐ To comply with a subpoena, warrant or court order compelling the production of information or with a rule of court that relates to the production of information (s.35(1)(i)) (Note – the recipient body must have jurisdiction to compel the production of information)
- ☐ To detect or prevent fraud, limit abuse in the use of health services or prevent the commission of an offence under an enactment of Alberta or Canada (s.35(1)(k)) (Note the recipient must be another custodian)
- ☐ To enable an officer of the Legislature (e.g. Auditor General, Ombudsman, Chief Electoral Officer, Information and Privacy Commissioner) to carry out his/her duties (s.35(1)(l))
- ☐ To avert or minimize an imminent danger to the health or safety of any person (s.35(1)(m))
- ☐ To act in the best interests of the above individual if the individual lacks the mental capacity to provide consent (s.35(1)(n))
- ☐ To provide necessary health services to a descendant of a deceased individual (s.35(1)(o)) (Note – the recipient must be a descendant or a representative under section 104(1)(c) to (i) and the privacy of the deceased individual must be protected)
- ☐ To comply with another act or regulation of Alberta or Canada that authorizes or requires the disclosure (s.35(1)(p))
- ☐ To transfer records to a successor custodian because the first custodian is ceasing to be a custodian or ceasing to provide health services within the geographic area in which the successor provides health services (s.35(1)(q))
- ☐ To provide information to obtain or process payment for health services provided to the above individual by a person that is required under a contract to pay for those services for the above individual (s.35(1)(r))
- ☐ To provide information to the College of Physicians and Surgeons of Alberta to administer the Triplicate Prescription Program (s.35(1)(s))
- ☐ To enable a health professional body to conduct an investigation, a discipline proceeding, a practice review or an inspection (s.35(4)) (Note—the custodian must comply with other relevant legislation and the health professional body must enter into an agreement with the custodian about non-disclosure and destruction of the information)
- ☐ To allow for permanent preservation and historical research by the Provincial Archives of Alberta or another archives that is subject to this Act or the Freedom of Information and Protection of Privacy Act (s.38) (Note—the custodian must determine that the information has enduring value)
- ☐ To enable the Minister of Health and Wellness to carry out his duties (s.40) (Note – the custodian must determine if the disclosure is necessary or desirable)

______________________________________ ____________________________

Name and Signature of Custodian (or affiliate) Date

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COMPONENTS FOR AN AFFILIATE'S OATH OF CONFIDENTIALITY

a statement, sworn (or affirmed) by the affiliate, stating that:

he/she will uphold to the best of his/her ability his/her duties under the *Health Information Act* and Regulations and the custodian's policies and procedures; and that

he/she will not disclose or make known any recorded or non-recorded health information of an individual except as authorized by the *Act,* the Regulations and the custodian's policies and procedures;

space for the city, town, village, etc. where the oath is sworn;
space for the date and signature of a witness;
place for a Commissioner for Oaths to commission the swearing (or affirming) of the Oath (optional)

HEALTH INFORMATION ACT
REQUEST FOR REVIEW

To: **Information and Privacy Commissioner**
Suite 410, 9925 – 109 Street
Edmonton, Alberta T5K 2J8

My Name Is:

My Mailing Address Is:

A telephone number where I can be reached during the day is:

On __________ I applied for my own health information from the following source:
Date

OR:

On _________ I asked to have my own health information corrected/amended by the following source:
Date

OR:
I am concerned about the following:

AND:
I am requesting a review by the Commissioner because:

(Please attach a copy of any correspondence you have received from the source you referred to.)

______________________________ ________________
Signature Date

If you have any questions, please call (780-422-6860)

This office will forward a copy of your completed form to the head of the custodian concerned and to any other person who in the opinion of the Commissioner is affected by the request. If concerns arise regarding this procedure, please make them known to the Commissioner as soon as possible.

Date Stamp Information and Privacy Commissioner

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APPENDIX 2

MODEL LETTERS

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Appendix 2
Model Letters

Introduction

The following sample letters are provided to assist custodians in corresponding with applicants, third parties and others in the processing of access and correction or amendment requests. The sample letters are intended to provide general guidance and may be altered to suit the circumstances of each request.

The letters are as follows:

A Acknowledgment of Request
A.1 Notice of Processing an Access Request under the *FOIP Act*
B Notice Regarding Extension of Time Limit
C Fee Estimate
D Abandonment of a Request
E Response to Access Request – Granting Access
F Response to Access Request – Denial of All or Part of Record(s)
G Response to Access Request – Record Does Not Exist
H Acknowledgment of Receipt of Correction or Amendment Request
H.1 Notice of Processing a Request for Correction or Amendment under the *FOIP Act*
I Notification Concerning a Request for Correction or Amendment
J Notice to Persons in Receipt of Health Information
K Notice Agreeing to Make a Correction or Amendment and Dispensing with Notification of Persons About a Correction or Amendment

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Model Letter A – Acknowledgment of Request

Purpose: *To acknowledge receipt of the applicant's request for information, to ask for clarification of a request and/or to request that initial fees be paid in order that the request may be considered complete and processing can commence.*

[*Reference number*]

[*Date*]

[*Applicant's name and address*]

Dear [*Applicant's name*]:

Re: Health Information Act
[*Request under Consideration*]

Your request for access to health information [*describe requested health information*] under the *Health Information Act* was received by [*custodian*] on [*date*].

Option A.1: General Acknowledgment

We will provide the information available to you under the *Act* as quickly as possible. Although the *Act* allows us a maximum of 30 days to respond, we will reply sooner than [*date*], if possible.

Option A.2: Need to Supply More Details

Unfortunately, your request for access to information does not provide sufficient specific details to identify the health records you may be requesting. [*Name of custodian*] cannot begin to process your request until we receive additional information to help us [*identify the record or make the request more specific*]. Please help us to clarify your request by supplying any of the following details of which you are aware:

[*list details you are requesting*]

Option A.3: Failure to Include Basic Fee

Unfortunately, you did not include the basic fee of $25.00. The *Act* allows us 30 days to respond to your request, but this time period will not commence until the basic fee has been received. Please forward the fee to [*appropriate address within the custodian*] as quickly as possible.

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Model Letter A – Acknowledgment of Request (continued)

The processing of the request will commence immediately upon the receipt of your fee.

Option A.4: Clarification of Request

We have now had an opportunity to discuss your request with you [*state method and date*]. We agreed that the request would now focus on [*describe the information agreed upon*]. If this understanding is not correct, please contact me at [*telephone #*] as soon as possible. This letter serves as a notice that it is this request which [*name of custodian*] is proceeding to process. We will provide the information available to you under the *Act* as quickly as possible. Although the *Act* allows us a maximum of 30 days to respond, we will reply sooner than [*date*], if possible.

Section 73 of the *Health Information Act* provides that you may make a written request to the Information and Privacy Commissioner to review this matter. You have 60 days from the date of this notice to request a review by writing to:

Information and Privacy Commissioner
410, 9925 – 109 Street
Edmonton, Alberta, T5K 2J8.

When requesting a review, please provide the Office of the Information and Privacy Commissioner with the following information:

1. The reference number noted at the top of this notice.
2. A copy of this letter.
3. A copy of your original request form that you sent to [*name of custodian*].

If you have any questions, please write to me or call me at [*telephone number*].

Sincerely,

[*Name*]
[*Title*]

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Model Letter A.1 – Notice of Processing an Access Request under the *FOIP Act*

> *Purpose: To acknowledge receipt of the applicant's request for information, and to give notice that all or part of the request will be processed under the FOIP Act.*

[*Reference number*]

[*Date*]

[*Applicant's name and address*]

Dear [*Applicant's name*]:

Re: Health Information Act
[*Request under Consideration*]

Your request for access to health information [*describe requested health information*] under the *Health Information Act* (the *Act*) was received by [*custodian*] on [*date*].

Some (or all) of the record(s) you requested contain information to which the *Freedom of Information and Protection of Privacy (FOIP) Act* applies. The request for these record(s) is deemed to be a request under section 7(1) of the *FOIP Act* and that *Act* applies to the processing of your (or that part of your) request.

Please see the attached letter related to your (or that part of your) request [*attach a letter acknowledging receipt of the access request under the FOIP Act – use Model Letter A from Appendix 3 – FOIP Guidelines and Practices (2005)*]

If you have any questions, please write to me or call me at [*telephone number*].

Sincerely,

[*Name*]
[*Title*]

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Model Letter B – Notice Regarding Extension of Time Limit

Purpose: To advise an applicant of a time extension taken to process a request.

[*Reference number*]

[*Date*]

[*Applicant's name and address*]

Dear [*Applicant's name*]:

Re: Health Information Act
[*Request under Consideration*]

[*Name of custodian*] received your request for access to information on [*date*].

Normally, [*name of custodian*] responds to a request for information within 30 days after receiving the request. However, in limited circumstances, the *Health Information Act* provides that a custodian may extend this time limit.

Option B.1: Time Extension to Clarify Request

In this case, there is a need for us to obtain more information from you before we can identify the records that deal with your request. We will need a time extension of [*number of days – up to 30 days or longer with Commissioner's permission*] to do this and identify the applicable records.

Option B.2: Consultation with Other Custodians

A preliminary review of the records you have requested indicates that consultations with (an) other custodian(s) may be required before we can fully process your request. This consultation is necessary for us to deal completely with the records that you have requested. We will require a time extension of [*number of days – up to 30 days or longer with Commissioner's permission*] to carry out this process.

Option B.3: Large Number of Records

Your request involves a large number of records. The volume of information involved cannot be processed within the usual 30-day limit. An extension of time of [*number of days – up to 30 days or longer with Commissioner's permission*] will allow [*name of custodian*] to provide you with a complete response to your request.

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[*Conclusion for all options*]

A response to your request will be ready no later than [*proposed date*]. We will try to respond sooner, if possible.

If you have any questions regarding this time extension, please contact [*name and job title*] at [*business address*] or telephone [*number*].

If you feel this time extension is unjustified, section 73 of the *Health Information Act* provides that you may ask the Information and Privacy Commissioner to review this decision. You have 60 days from the date of this notice to request a review by writing to:

Information and Privacy Commissioner
410, 9925 – 109 Street
Edmonton, Alberta, T5K 2J8.

When requesting a review, please provide the Office of the Information and Privacy Commissioner with the following information:

1. The reference number quoted at the top of this notice.
2. A copy of this letter.
3. A copy of your original request for information that you sent to [*name of custodian*].

If you have any questions, please write or call me at [*telephone number*].

Sincerely,

[*Name*]
[*Title*]

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Model Letter C – Fee Estimate

Purpose: To advise an applicant of the amount of fees that will be involved in processing a request.

[*Reference number*]

[*Date*]
[*Applicant's name and address*]

Dear [*applicant's name*]:

Re: Health Information Act
[*Request under Consideration*]

[*Name of custodian*] received your request for access to health information [*describe requested health information*] on [*date*]. Section 67 of the *Health Information Act* provides that fees may be charged for providing you with the information which you requested.

Fees, over and above the basic fee paid at the time you made the request, are assessed because [*provide rationale for fees being assessed*].

The fee for providing the health records you have requested is estimated to be [*$ amount*]. We have calculated this amount as follows:

[*provide calculation*]

Option C.1: Deposit

Please reply to us in writing within 20 days of the date of this notice indicating that you accept this estimate and enclose a deposit of [*$ amount*][*do not send cash*] made payable to [*the appropriate officer of custodian*]. This reply must be sent to [*name of officer, office and address of custodian*] and should quote the reference number provided at the top of this letter. When we have received your response and deposit, processing of your request will continue.

Option C.2: No Deposit

Please reply to us in writing within 20 days of the date of this notice indicating that you accept this estimate and will pay these fees when requested to do so. Please send the reply to [*name of officer, offices and address of custodian*] and quote the reference number provided at the top of this letter. When we have received your response, processing of your request will continue. Please do not send cash.

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Model Letter C – Fee Estimate (continued)

Option C.3: Refusal of Request to Excuse Fee

Your request for excusing the payment of the fee cannot be granted [*state reason*]. Please reply to us in writing within 20 days of the date of this notice indicating that you accept this estimate and enclose a deposit of [*specify amount*] [*do not send cash*]. Please send the reply to [*name of officer, offices and address of custodian*] and quote the reference number provided at the top of this letter. When we have received your response, your request will be processed.

If you find the fees a burden to you, we would be pleased to discuss approaches to processing the request which may reduce the fees and still provide the information you require. Please write or call [*name, title, address and telephone number*], who may be able to assist you.

[*For options C.1 and C.2*]

Section 67(4) provides some limited situations where fees can be excused, if you cannot afford to pay the fee or if, in the opinion of the custodian, it is fair to excuse payment. If you believe that one of these circumstances applies to you, you should raise it with the officer mentioned above.

[*Conclusion for all options*]

Section 73 of the legislation allows you to ask the Information and Privacy Commissioner to review this fee estimate and any decision made on a request for excusing of a fee payment. The *Act* allows you 60 days from the date you receive this notice to request a review by writing to

Information and Privacy Commissioner
410, 9925 – 109 Street
Edmonton, Alberta, T5K 2J8.

When requesting a review, please provide the Office of the Information and Privacy Commissioner with the following information:

1. The reference number quoted at the top of this notice.
2. A copy of this letter.
3. A copy of your original request for information that you sent to [*name of custodian*].

If you have any questions, please write or call the officer named above or myself at [*telephone number*].

Sincerely,

[*Name*]
[*Title*]

Model Letter D – Abandonment of Request

Purpose: To inform the applicant that his or her request is going to be considered abandoned under section 9.

Note: *The time line to allow the applicant to reactivate the request within 12 months is a suggested guideline, not a requirement of the Act. Custodians may choose to alter this according to the nature of the request or the records involved.*

[*Reference number*]

[*Date*]

[*Applicant's name and address*]

Dear [*Applicant's name*]:

Re: Health Information Act
[*Request under Consideration*]

Option D.1: Abandonment Indicated

You indicated to us on [*date*] that you were abandoning your request [*reference number and subject*]. If you wish to reactivate your request at any time up to [*date 12 months from the date of closure*], you may do so without making another request or submitting an initial fee. After that date, you will have to submit another request and any initial fee that may be required.

Option D.2: Abandonment Not Indicated

We have not received any communication concerning your request since [*date of letter seeking further information or requesting fee*]. For this reason, we are closing the file on your request [*reference number and subject*]. If you wish to reactivate your request at any time up to [*date 12 months from the date of closure*], you may do so without making another request or submitting an initial fee. After that date, you will have to submit another request and any initial fee that may be required.

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Model Letter D – Abandonment of Request (continued)

If you disagree with this decision, section 73 of the *Health Information Act* provides that you may ask the Information and Privacy Commissioner to review this decision. You have 60 days from the date of this notice to request a review by writing to:

Information and Privacy Commissioner
410, 9925 – 109 Street
Edmonton, Alberta, T5K 2J8.

When requesting a review, please provide the Office of the Information and Privacy Commissioner with the following information:

1. The reference number quoted at the top of this notice.
2. A copy of this letter.
3. A copy of your original request for information that you sent to [*name of custodian*].

If you have any questions, please write or call me at [*telephone number*].

Sincerely,

[*Name*]
[*Title*]

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Model Letter E – Response to Access Request – Granting Access

Purpose: To inform an applicant that access will be granted.

[*Reference number*]

[*Date*]

[*Applicant's name and address*]

Dear [*Applicant's name*]:

Re: Health Information Act
[*Request Under Consideration*]

I am responding to your request of [*date*] for access to health information [*describe requested information]*. We are pleased to provide access to [*specify subject and records generally*].

Option E.1: Copy Enclosed

A copy of the information is enclosed.

Option E.2: Applicant to View Originals

You have requested an opportunity to examine the original records containing your health information rather than receive copies of them. We invite you to examine the record(s) at [*place and address*] on [*date*] at [*time*]. If you are unable to examine the records at that time, please contact [*name and telephone number*] to make alternate arrangements.

Option E.3: Records Cannot be Copied

The record(s) containing the health information you have requested cannot be copied because [*provide reason*]. We invite you to examine the original record(s) at [*place and address*] on [*date*] at [*time*]. If you are unable to examine the record(s) at that time, please contact [*name and telephone number*] to make alternate arrangements.

Option E.4: Fees Required

As we informed you in our fee estimate of [*date*], your request has now been processed and fees totaling [*$ amount and calculation, if previous deposit received*] must be paid before access can be provided.

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Please make your cheque or money order payable to [*name of custodian*] and send it to [*name of officer, office and address of custodian*].

If you feel that your request has not been answered completely or that you require further clarification, please contact [*name and job title*] at [*business address and telephone number*].

Under section 73 of the *Health Information Act*, you may ask the Information and Privacy Commissioner to review the assessment of a fee or any other matter concerning this response to your request. You have 60 days from the date of this notice to request a review by writing to:

Information and Privacy Commissioner
410, 9925 – 109 Street
Edmonton, Alberta, T5K 2J8.

If you wish to request a review, please provide the Office of the Information and Privacy Commissioner with the following information:

1. The reference number quoted at the top of this notice.
2. A copy of this letter.
3. A copy of your original request for information that you sent to [*name of custodian*].

If you have any questions, please write or call me at [*telephone number*].

Sincerely,

[*Name*]
[*Title*]

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Model Letter F – Response to Access Request – Denial of All or Part of Record*(s)*

Purpose: *To inform an applicant that access to all or part of the records requested has been denied.*

[*Reference number*]

[*Date*]

[*Applicant's name and address*]

Dear [*Applicant's name*]:

Re: Health Information Act
[*Request under Consideration*]

I am replying to your request of [*date*] for access to [*describe requested health information*].

Option F.1: Total Denial

Unfortunately, access to all the health information that you requested is refused under section(s) [*put in an explanation, including the detailed sections on which refusal is based (identify exception(s) used from section 11(a) or (b)*].

Option F.2: Some Records Available

I am pleased to inform you that access is being provided to [*specify particular records*].

A copy of the record(s) containing your health information is attached; or

You asked to examine the original records containing your health information rather than receive copies. We invite you to examine the record(s) at [*place and address*] on [*date*] at [*time*]. If you are unable to examine the records at that time, please contact this office to make alternative arrangements; or

The record(s) containing your health information to which you are being given access cannot be copied. We invite you to examine the original record(s) at [*place and address*] on [*date*] at [*time*]. If you are unable to examine the record(s) at that time, please contact this office to make alternative arrangements.

Access to all other records has been denied under section(s) [*give detailed sections*] of the *Health Information Act.*

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Model Letter F – Response to Access Request – Denial of All or Part of Record(s) (continued)

Option F.3: Severed Information

Some of the records you requested contain information that is excepted from disclosure under *the Health Information Act*. We have severed the excepted information so that we could disclose to you the remaining information in the records.

The severed information is excepted from disclosure under sections [*provide section numbers and descriptors*] of the *Act*. The detailed sections supporting the excising of particular information is [*provided in the attached list or indicated on the face of each record*].

Under section 73 of the *Health Information Act*, you may ask the Information and Privacy Commissioner to review the decision not to disclose information that you requested. You have 60 days from the receipt of this notice to request a review by writing to:

Information and Privacy Commissioner
410, 9925 – 109 Street
Edmonton, Alberta, T5K 2J8.

OR

We are disclosing (all or part of the particular records) outside the provisions of the *Health Information Act* and a copy of these is enclosed.

[***If fees are to be charged, reference should be made to the options for additional wording in Model Letter E.***]

Under section 73 of the *Health Information Act*, you may ask the Information and Privacy Commissioner to review the decision that the records that you requested are excluded from the scope of the *Act*. You have 60 days from the receipt of this notice to request a review by writing to:

Information and Privacy Commissioner
410, 9925 – 109 Street
Edmonton, Alberta, T5K 2J8.

If you wish to request a review, please provide the Office of the Information and Privacy Commissioner with the following information:

1. The reference number quoted at the top of this notice.
2. A copy of this letter.
3. A copy of your original request for information that you sent to [*custodian*].

If you have any questions about this letter, please write or call me at [*telephone number*].

Sincerely,

[*Name*]
[*Title*]

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Model Letter G – Response to Access Request – Record Does Not Exist

Purpose: To advise an applicant that a record does not exist.

[*Reference number*]

[*Date*]

[*Applicant's name and address*]

Dear [*Applicant's name*]:

Re: Health Information Act
[*Request under Consideration*]

I am writing about your request of [*date*] for access to information under the *Health Information Act*.

I regret to inform you that a search by [*name of custodian*] has failed to retrieve any records relating to the subject of your request. [*Outline all steps taken to locate records and, if the records have been destroyed, provide information, if possible, as to when and under what authority this was done.*]

Under section 73 of the *Health Information Act*, you may ask the Information and Privacy Commissioner to review the finding that records pertinent to the request [*could not be located or have been destroyed*]. You have 60 days from the date of this notice to request a review by writing to:

Information and Privacy Commissioner
410, 9925 – 109 Street
Edmonton, Alberta, T5K 2J8.

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If you wish to request a review, please provide the Office of the Information and Privacy Commissioner with the following information:

1. The reference number quoted at the top of this notice.
2. A copy of this letter.
3. A copy of your original request for information that you sent to [*name of custodian*].

If you have any questions about this letter, please write or call me at [*telephone number*].

Sincerely,

[*Name*]
[*Title*]

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Model Letter H – Acknowledgment of Receipt of Correction or Amendment Request

Purpose: *To acknowledge receipt of the applicant's request to correct his or her personal information.*

[*Reference number*]

[*Date*]

[*Applicant's name and address*]

Dear [*Applicant's name*]:

Re: Health Information Act
[*Request for Correction or Amendment under Consideration*]

Your request for correction or amendment of health information [*describe requested correction or amendment]* under the *Health Information Act* [the *Act*] was received by [*name of custodian*] on [*date*].

We will respond to your request by [*date*], or sooner if possible.

If you have any questions, please write to me or call me at [*telephone number*].

Sincerely,

[*Name*]
[*Title*]

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Model Letter H.1 – Notice of Processing a Request for Correction or Amendment under the *FOIP Act*

Purpose: To acknowledge receipt of the applicant's request to correct his or her health information and to give notice that all or part of the request will be processed under the FOIP Act.

[*Reference number*]

[*Date*]

[*Applicant's name and address*]

Dear [*Applicant's name*]:

Re: Health Information Act
[*Request for Correction or Amendment under Consideration*]

Your request for correction or amendment of health information [*describe requested correction or amendment]* under the *Health Information Act* [the *Act*] was received by [*name of custodian*] on [*date*].

Some (or all) of the records you requested to be amended contain information to which the *Freedom of Information and Protection of Privacy (FOIP) Act* applies. The request for correction or amendment of those records is deemed to be a request under Section 35 of the *FOIP Act* and that *Act* applies to the processing of your (or that part of your) request.

Please see the attached letter related to your (or that part of your) request [*attach a letter acknowledging receipt of request for correction under the FOIP Act – use Model Letter R from Appendix 3 – FOIP Guidelines and Practices (2005)*].

If you have any questions, please write to me or call me at [*telephone number*].

Sincerely,

[*Name*]
[*Title*]

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Model Letter I – Notification Concerning a Request for Correction or Amendment

Purpose: *To advise an individual whether or not a request for correction or amendment has been agreed to and other parties have been notified and, where it has not, what the applicant's options are.*

[*Reference number*]

[*Date*]

[*Applicant's name and address*]

Dear [*Applicant's name*]:

Re: Health Information Act
[*Request for Correction or Amendment under Consideration*]

Option I.1: Correction or Amendment Agreed To

Your request for a correction or amendment of [*error or omission*] has been agreed to by [*name of custodian*] and your record has been corrected or amended as you requested.

A copy of your new record incorporating the correction or amendment accompanies this notice [*or you can inspect the corrected or amended record at – name and address of appropriate office*].

The following persons, [*name persons*], to which the information has been disclosed over the last year have been informed of the facts of [*the correction or amendment*] and requested to amend their files to reflect this information.

Option I.2: Correction Refused

Your request for a correction or amendment of [*error or omission*] has been refused by [*name of custodian*], you may either:

(a) Ask for a review of this decision by the Information and Privacy Commissioner under section 73 of the Act;

OR

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Model Letter I – Notification Concerning a Request for Correction or Annotation (continued)

(b) Submit within 30 days of receiving this notice a statement of disagreement to [*the custodian*] setting out in 500 words or less the requested correction or amendment and your reasons for disagreeing with this decision.

[*If applicant submits a statement of disagreement*] Your statement of disagreement will be attached to the record that is the subject of the requested correction or amendment and will be provided to any person to whom [*name of custodian*] has disclosed the record in the year prior to your request.

[*In the case of refusal*] You may request the Information and Privacy Commissioner to review our decision to refuse to correct or amend your health information. The *Act* allows you 60 days from the date you receive this notice to request a review by writing to:

Information and Privacy Commissioner
410, 9925 – 109 Street
Edmonton, Alberta, T5K 2J8.

If you wish to request a review, please provide the Office of the Information and Privacy Commissioner with the following information:

1. The reference number quoted at the top of this notice.
2. A copy of this letter.
3. A copy of your original request for correction which you sent to [*name of custodian*].

If you have any questions, please write to me or call me at [*telephone number*].

Sincerely,

[*Name*]
[*Title*]

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Model Letter J – Notice to Persons in Receipt of Health Information

Purpose: To advise persons who have received health information that a correction or amendment has been made or that a statement of disagreement has been submitted.

[*Reference number*]

[*Date*]

[*Name of person and address*]

Dear [*Name of official*]:

Option J.1: Correction or Amendment Made

On [*date*], [*name of custodian*] disclosed to you information concerning [*name of individual requesting correction or amendment*]. This information has [*been corrected or amended and a copy of the corrected record is attached*]. Section 13(3)(c) of the *Health Information Act* requires that we notify you of this correction. Please amend your records or link the correction or amendment to them in order to ensure that they contain this new information.

Option J.2: Statement of Disagreement Submitted

On [*date*], [*name of custodian*] disclosed to you information concerning [*name of individual requesting correction or amendment*]. This information has not been corrected or amended but [*name of individual*] has submitted a statement of disagreement under section 14(1)(b) of the *Health Information Act*. Section 14(3) of that *Act* requires that we provide a copy of this statement of disagreement to you to attach to the information that was disclosed to you (see attached statement).

Sincerely,

[*Name*]
[*Title*]

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Model Letter K– Notice Agreeing to Make a Correction or Amendment and Dispensing with Notification of Persons About a Correction or Amendment

> *Purpose: To advise an applicant that a request for correction or amendment has been agreed to and to obtain the applicant's consent to dispense with notifying other persons about the correction or amendment.*

[Reference number]

[Date]

[Applicant's name and address]

Dear [Applicant's name]:

Re: Health Information Act
[Request for Correction or Amendment under Consideration]

Your request for a correction or amendment of [error or omission] has been agreed to by [name of custodian] and your record has been corrected or amended as you requested. The record containing the information that you requested to be corrected or amended has been disclosed over the last year to the following persons [name persons]:

Since [name of custodian] believes that you will not be harmed if the above persons are not notified about the correction or amendment, we are asking for your consent to dispense with notifying those persons under section 13(4) of the *Health Information Act*.

Please sign and return the attached form, indicating whether you consent to dispensing with notification.

If you have any questions, please write to me or call me at [telephone number].

Sincerely,

[Name]
[Title]

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Model Letter K– Notice Agreeing to Make a Correction or Amendment and Dispensing with Notification of Persons About a Correction or Amendment (Continued)

Consent to Dispense with Notification About a Correction or Amendment

I, [Name of Applicant] consent to [Name of Custodian] not notifying the persons to which my health information has been disclosed during the year prior to my request for a correction or amendment, dated [date of request], that my health information has been corrected or amended.

Dated this [day] of [month], [year]

Expiry date [day] of [month], [year]

[Signature of Applicant]

[Name of Applicant]

[Witness Signature] [Witness Name]

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