

Clinic Name _____

Clinic Address _____

Clinic Phone Number, Fax Number, Email _____

Names of Treatment Provider(s) _____

Request for Patient Health Information

Date: _____

To: Nova Scotia Health
Health Information Services

Fax: 902-473-4999

Email: HISCustSvc@cdha.nshealth.ca

IWK Health

Fax: 902-470-7463

I am requesting the following patient information as listed below. This information will be used to support the delivery of care and treatment management for the patient. I confirm that I am a regulated Nova Scotia health professional and require the information to carry out treatment duties.

I understand that the patient may request to limit or revoke the release of personal health information.

Requested Patient Information

Patient Full Legal Name: _____

Date of Birth (DD/MM/YYYY): _____ Health Card #: _____

☐ Diagnostic Imaging Reports: Type of images: _____

Approx date or date range: _____

Studies of: _____

☐ Diagnostic Images: Type of images: _____

Approx date or date range: _____

Studies of: _____

☐ Other (please provide details of requested results/reports): _____

Approx date or date range: _____

Studies of (if applicable): _____

☐ Facility that completed Diagnostic Imaging: _____

Please send the reports via ☐ Fax: _____ ☐ Email: _____ to:

☐ DC name(s): _____