BC CANCER SCREENING
Provincial Health Services Authority

BREAST AND LUNG SCREENING

Request for Access to Records

General Information/Personal Information

This request is for: ☐ BC Cancer Breast Screening ☐ BC Cancer Lung Screening

STEP 1 Patient Information

FIRST NAME	MIDDLE NAME	LAST NAME	
PHN		DATE OF BIRTH (YYYYMMDD)	
MAILING ADDRESS		CITY/TOWN	PROVINCE / POSTAL CODE
TELEPHONE NUMBER		ALTERNATIVE TELEPHONE NUMBER	FAX NUMBER

DETAILS OF REQUESTED INFORMATION

Please describe the records you are requesting: (be specific as possible including dates, if known, as this will assist in the request process)

_____

_____

_____

_____

Please specify References, File #s or Program ID, if known: _____

STEP 2 Delivery Information

Information to be provided to: ☐ Self ☐ Other (provide name/organization and address):

_____

_____

Preferred method of delivery: ☐ Mail ☐ In-Person Pick-Up (picture ID to be presented)

Are you acting on behalf of patient as their representative to request their personal information? Yes ☐ No ☐

If 'YES' attach as appropriate a) patient's signed consent for disclosure, or b) proof of authority to act on the person's behalf.

PATIENT SIGNATURE _____ DATE SIGNED (YYYMMDD) _____

REPRESENTATIVE SIGNATURE (if applicable) _____ REPRESENTATIVE FULL NAME (if applicable) _____

STEP 3 Submit Form to BC Cancer Screening Client Services Centre

Submit this form either by Fax (604-877-6115) or mail to:

BC Cancer Screening Client Services Centre
Suite 711, 750 West Broadway
Vancouver, BC V5Z 1J4

Requests will be processed within 14 - 21 business days. Personal information contained on this form is collected under the Freedom of Information and Protection of Privacy Act and will be used only for the purpose of responding to your request.