

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 (YYYYMMDD) _____

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