BC CANCER BREAST SCREENING
Provincial Health Services Authority

# REQUEST FOR ACCESS TO RECORDS

General Information/Personal Information

**Name of public body to which you are directing your request: BC Cancer Breast Screening**

| | | |
|---|---|---|
| Last Name | First Name | Middle Name |
| Date of Birth | PHN | |
| Mailing Address | City/Province | Postal Code |
| Daytime Phone Number | Alternative Phone Number | Day Fax |

**Details of Requested Information**

Information requested (please describe the records you are requesting, be as specific as possible, as this will assist in the request process. (Use the back to this form if the space below is not sufficient.)

Please specify any References or File Number(s) if known: _____

**Information to be provided to:**

☐ **Self** ☐ **Name/Organization/Address**

_____

_____

**Are you requesting access to another person's personal information?** ☐ **Yes** ☐ **No**

If so, attach as appropriate: **a)** that person's sign consent for disclosure, or **b)** proof of authority to act on the person's behalf.

**Preferred method of delivery:** ☐ **Mailed** ☐ **Patient to pickup (bring picture ID)**

| | |
|---|---|
| Witness Signature | Patient Signature |
| Witness Name (Print) | Substitute Signature |
| Relationship to Patient | Substitute Name (Print) |
| Date signed | Reason for Substitute |

**Note:**

Requests will be processed within 14 – 21 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.

Please complete this form and fax to 604.877.6115 or mail to:

BC Cancer Screening Client Services Centre
Suite 711, 750 West Broadway
Vancouver, BC V5Z1H1