

PLEASE NOTE: Your request cannot be processed until the Centre for Health Information has been able to contact you by telephone to verify your information. Once your request has been processed by the Privacy Team, it may take up to two business days to have your password applied to your record.

To request a HEALTHe NL profile audit, please:

- Complete the appropriate fields and sign at the bottom
- Send the signed and completed form to the mailing address indicated

PART 1: ABOUT YOU

Section A: Please complete the following information about yourself or the individual for whom you are seeking a profile audit for.

LAST NAME	FIRST NAME	MIDDLE INITIAL(S)
<input type="text"/>	<input type="text"/>	<input type="text"/>
MAILING ADDRESS		
APT/UNIT	STREET NUMBER	STREET NAME
<input type="text"/>	<input type="text"/>	<input type="text"/>
CITY/TOWN	PROVINCE	POSTAL CODE
<input type="text"/>	<input type="text"/>	<input type="text"/>
DAYTIME TELEPHONE NUMBER	BIRTHDATE (DD/MM/YYYY)	SEX (CHECK ONE)
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Other <input type="checkbox"/> Female <input type="checkbox"/> Unknown
		MCP NUMBER
		<input type="text"/>

SECTION B: If you **do not** have an MCP Number, please fill in your health card number and issuing jurisdiction below.

HEALTH CARD NUMBER	PROVINCE, TERRITORY OR FEDERAL AUTHORITY
<input type="text"/>	<input type="text"/>

SECTION C: If you are acting on behalf of another individual, complete the following section with your information. If you are requesting a profile audit for a minor, all parents or guardians will be asked to provide consent. See page two, Part 4 of this form

LAST NAME	FIRST NAME	DAYTIME TELEPHONE NUMBER
<input type="text"/>	<input type="text"/>	<input type="text"/>

MAILING ADDRESS (IF DIFFERENT FROM ABOVE)

APT/UNIT	STREET NUMBER	STREET NAME OR POST OFFICE BOX	POSTAL CODE
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
CITY/TOWN	PROVINCE	Why can you request this individual's information? (See page two for details)	
<input type="text"/>	<input type="text"/>	<input type="text"/>	

PART 2: ABOUT YOUR REQUEST

SECTION A: Please select the type of request you are making

- Request a HEALTHe NL Profile Audit

SECTION B: How would you like to receive the requested document?

- Pick-up, 70 O'Leary Ave., St. John's
 Mail, Registered mail to the address indicated above

PART 4: SIGNATURE

Please sign and date this form and return it to the address provided on page two.

<u>X</u> _____	_____	<u>X</u> _____	_____
Your signature	Date signed (DD/MM/YYYY)	Other parent/guardian signature	Date signed (DD/MM/YYYY)

Instructions for Completing the Form

The personal information collected as part of the application process is required to identify you and prove your identity. In the case where you are requesting a profile audit on behalf of someone else, the information is also required to identify the patient and confirm that you are authorized to act on their behalf. The personal information is collected under the authority of the *Access to Information and Protection of Privacy Act* and the *Personal Health Information Act*.

Part 1: About you

Section A (about the individual's personal information):

- Fill in this section about the person for whom you are requesting a profile audit for (yourself or the person for whom you are acting on behalf of).

Section B (if you do not have an MCP Number):

- If you do not have a MCP number, please use the health card number from your province, territory or other jurisdiction.

Section C (acting on behalf of another individual):

- An authorized representative is a person permitted to exercise the rights of an individual. This allows a trusted person to act on an individual's behalf.
- If you are requesting a profile audit on someone else's personal health information, please fill in Section C with your own information (fill in Section A with the individual's information).
- Indicate why you can request this individual's information. You must provide documentation to support your authority to do so.

Part 2: About your request

- Please indicate if this request is for a HEALTHe NL Profile Audit
- Please indicate the method of delivery for the requested document

Part 4: Signature

- Please sign and date the completed form
- By signing the form, I acknowledge that:
I have read and understood the information provided on this form and agree to:
 - Have a profile audit completed on my HEALTHe NL profile
 - Have the audit printed and made available to me either via mail or in person pick-up
- If you are requesting the audit for a minor, all parents/guardians will be required to sign and date the form.

How do you submit this form?

By Mail:

NL Centre for Health Information
ATTN: Consent Administrator
70 O'Leary Ave
St. John's, NL A1B 2C7

Please write confidential on your envelope

Due to the sensitive nature of information included with your application, you are encouraged to send it via registered mail.

The Centre for Health Information is not responsible for completed applications and supporting documentation which are lost or intercepted in transit.

For more information or to request forms:

Phone: (709) 752-6000

Email: privacy@nlchi.nl.ca