C.W. WIEBE MEDICAL CENTRE

385 Main St. Winkler, MB R6W 1J2
Phone (204)325-4312 Fax (204)325-4594
Email: info@cwwiebemedical.ca
cwwiebemedical.ca

Request to Access Personal Health Information

I,_____ (name of applicant) request that the C.W. Wiebe Medical Centre provide access to the personal health information of

Client Name: _____
Address: _____
Date of Birth: _____PHIN/MHSC: _____
Telephone: _____Email: _____

Specific Information Requested: _____

Signature of Requestor: _____Date: _____

Are you requesting a copy of this information? Yes ○ No ○
Are you disenrolling as a patient from the C. W. Wiebe Medical Centre? Yes ○ No ○
Disenrollment Reason: ○ Moved ○ Enrolling to a new Provider ○ Patient Request
Disenrollment Date: _____

Person Requesting Access (if different from above):

Name:_____
Address:_____
Telephone Number: _____
Legal Authority for Request: _____
Signature of Requestor:_____Date: _____

You will be contacted within 30 days of receipt of your request, and the availability of the information requested will either be granted or refused based upon The Personal Health Information Act. If the information is available, be advised that a fee will be charged.

To be filled out by Responsible Physician / Privacy Officer:

Signature: _____ Date Received: _____