

## All sites and facilities

## **Mature Minor Requesting Their Health Records**

Page 1 of 1

Name):		
NH Nu	mber:	Chart Created: Y/N
Gender:	Age:	Encounter Type:
ment:	PHN:	
an/Attending	Physical:	
	NH Nu Gender: ment:	NH Number: Gender: Age:

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.

I would like to request unrestricted access to my personal health information contained within HealtheLife/

City/Town: Province:	Health Record:	
PHN (Provincial Health Number/Care Card):    Day Phone:	Name (First/Middle/Last):	
PHN (Provincial Health Number/Care Card):    Day Phone:	Date of Birth: (dd/mm/yyyy):	
Day Phone:		
Mailing Address:  City/Town:  Province:  Country:  Postal Code:  SECTION BELOW TO BE COMPLETED BY A PHYSICIAN, NURSE PRACTITIONER, OR PSYCHOLOGIST  the Minor above has requested to have unrestricted access to his/her Personal Health Record via the Northern Healt ratient Portal - HealtheLife/Health Record.  IdealtheLife is an online web-based system that displays current available information contained in the Northern Healt interprise Information System (Cerner). Additional information will be made available in the future.  Is his/her Health Care Provider, you are requested to complete this form to confirm that the minor is sufficiently matured capable to understand the information contained in their Personal Health Record.  Indinor is defined as anyone under the Age of Majority (19 years in B.C.)  It confirm as of this date that this Patient,  (name of patient)  (name of pat		
City/Town:		
Country:		
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have unrestricted access to their personal health information contained within HealtheLife/Health Record:  Health Care Provider Name (First/Middle/Last):	A Minor is defined as anyone	under the Age of Majority (19 years in B.C.)
have unrestricted access to their personal health information contained within HealtheLife/Health Record:  Health Care Provider Name (First/Middle/Last):	I confirm as of this date that	at this Patient,, is sufficiently mature / capable to
Health Care Provider Specialty (Profession or Society):  MSP Signature: Date: Phone Number:  Mailing Address:  City/Town: Province:  Country: Postal Code:  Minors have the option to request access to their health care record information at the Health Records Department of their local NH facility. The minor is to present this form and identification to health records for verification.	have unrestricted access t	o their personal health information contained within HealtheLife/Health Record:
Signature:  Date:	Health Care Provider Name	(First/Middle/Last):
Date: Phone Number: Province: Province: City/Town: Province: Postal Code: Ote: The signing of this form is for Information Access only; it does not apply for Emergency Health Care or Treatment. Minors have the option to request access to their health care record information at the Health Records Department of their local NH facility. The minor is to present this form and identification to health records for verification.	Health Care Provider Specia	Ity (Profession or Society):
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	Signature:	t circotus)

