Vancouver CoastalHealth
*Promoting wellness. Ensuring care.*

# PATIENT/CLIENT REQUEST FOR HEALTH RECORDS FOR REVIEW PANEL HEARING

## Part 1: Patient / Resident Information

| LAST NAME | FIRST NAME | ALSO KNOWN AS / ALIAS |
|---|---|---|
| | | |

| ADDRESS | CITY / PROVINCE | POSTAL CODE |
|---|---|---|
| | | |

| TELEPHONE NUMBER | DATE OF BIRTH DD \| MM \| YYYY | PERSONAL HEALTH NUMBER (CARECARD) |
|---|---|---|
| | | |

## Part 2: Records Requested

NAME OF HOSPITAL / COMMUNITY TEAM / PROGRAM:

| | |
|---|---|
| ☐ HOSPITAL VISIT | DATE(S) OF RECORDS REQUESTED: |
| ☐ COMMUNITY TEAM / PROGRAM | DATE(S) OF RECORDS REQUESTED: |

## Part 3: Patient / Client Authorization

SIGNATURE OF PATIENT/CLIENT:_____DATE SIGNED: _____

*The information on this form is collected pursuant to section 25 of the Mental Health Act. It will be used to release information from the patient's personal health record to be used as evidence during a review panel hearing. Any questions you have about this form may be addressed to the director or staff of this facility.*