Manitoba Child and Family Services

PERSONAL HEALTH INFORMATION REQUEST FORM

When seeking personal health information from Manitoba Health, Healthy Living and Seniors (MHHLS), a Regional Health Authority, a public health program, a health care facility, or a private practitioner.

SECTION 1: COLLECTION AUTHORITY – This form is a onetime request for personal health information for the purpose of:	
☐	Conducting a child protection investigation pursuant to Subsection 18.4(1) of *The Child and Family Services Act.*
☐	Providing child protection services pursuant to Subsection 18.4(1) of *The Child and Family Services Act.*
☐	Caring for a child under apprehension pursuant to Subsection 25(1) of *The Child and Family Services Act.*
☐	Fulfilling responsibilities as temporary or permanent guardian as per an order from *The Court of Queen's Bench*.
☐	Notifying an individual of a hearing pursuant to Subsection 20(2), 25(4) or 30(1) of *The Child and Family Services Act.*
☐	Other: _____ ***(Please contact MHHLS directly at 204-788-6612 to verify this authority)***

SECTION 2: TRUSTEE INFORMATION – What trustee is the information being requested from?	
Name of Department/Facility/Program:	Health Practitioner Name (if known):

SECTION 3: CHILD AND FAMILY SERVICES CONTACT INFORMATION		
Authority: ☐ General ☐ First Nations of Northern MB ☐ First Nations of Southern MB ☐ Métis		
CFS Agency:	CFS Worker:	
Phone:	Fax:	
Address:	City/Town:	Postal Code:
Signature:	Date of Request:	

SECTION 4: TIMEFRAME FOR PROVIDING INFORMATION		
☐ IMMEDIATELY	☐ WITHIN 2 WEEKS	☐ WITHIN 30 DAYS

SECTION 5: INFORMATION IS BEING SOUGHT ON THE FOLLOWING INDIVIDUAL(S) CHECKED BELOW:				
☐	Mother's Last Name:		First:	Middle:
	PHIN:		Registration No.:	D.O.B.:
	Address:		City/Town:	Postal Code:
☐	Father's Last Name:		First:	Middle:
	PHIN:		Registration No.:	D.O.B.:
	Address:		City/Town:	Postal Code:
☐	Other Person - Last Name:		First:	
	☐ M ☐ F	PHIN:	Registration No.:	D.O.B.:
	Address:		City/Town:	Postal Code:

☐	Child 1 Last Name:		First:	☐ in care ☐ not in care
	☐ M ☐ F	PHIN:	Registration No.:	D.O.B.:
☐	Child 2 Last Name:		First:	☐ in care ☐ not in care
	☐ M ☐ F	PHIN:	Registration No.:	D.O.B.:
☐	Child 3 Last Name:		First:	☐ in care ☐ not in care
	☐ M ☐ F	PHIN:	Registration No.:	D.O.B.:
☐	Child 4 Last Name:		First:	☐ in care ☐ not in care
	☐ M ☐ F	PHIN:	Registration No.:	D.O.B.:

SECTION 6: PERSONAL HEALTH INFORMATION BEING REQUESTED

List the ***specific*** information being requested (include dates if possible):

_____

_____

_____

_____

_____

SECTION 7: DISCLOSING TRUSTEE'S INFORMATION

Disclosing Employee:		Phone:
Position:		Fax:
☐	Requested information provided.	☐ By phone: HARDCOPY FOLLOW-UP REQUIRED ☐ By mail ☐ By courier ☐ By fax ☐ Pickup by authorized person
☐	Requested information provided ***in part***.	Explanation:
☐	Requested information ***not*** provided.	Explanation:
Signature:		Date:

This form will become part of the permanent health record and CFS record of the subject individual(s).

THIS FORM HAS BEEN CREATED AND AGREED TO BY MANITOBA HEALTH, HEALTHY LIVING AND SENIORS, CHILD AND FAMILY SERVICES AND THE MANITOBA REGIONAL HEALTH AUTHORITIES.

Do you have questions or concerns regarding this form?
Contact MHHLS at 204-788-6612 or by email at PHIAinfo@gov.mb.ca.