

**PERSONAL HEALTH INFORMATION REQUEST FORM**


When seeking personal health information from Manitoba Health, Healthy Living and Seniors (MHLS), 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:**

<input type="checkbox"/>	Conducting a child protection investigation pursuant to Subsection 18.4(1) of <i>The Child and Family Services Act</i> .
<input type="checkbox"/>	Providing child protection services pursuant to Subsection 18.4(1) of <i>The Child and Family Services Act</i> .
<input type="checkbox"/>	Caring for a child under apprehension pursuant to Subsection 25(1) of <i>The Child and Family Services Act</i> .
<input type="checkbox"/>	Fulfilling responsibilities as temporary or permanent guardian as per an order from <i>The Court of Queen's Bench</i> .
<input type="checkbox"/>	Notifying an individual of a hearing pursuant to Subsection 20(2), 25(4) or 30(1) of <i>The Child and Family Services Act</i> .
<input type="checkbox"/>	Other: _____ <i>(Please contact MHLS directly at 204-788-6612 to verify this authority)</i>

**SECTION 2: TRUSTEE INFORMATION – What trustee is the information being requested from?**

Name of Department/Facility/Program:	Health Practitioner Name (if known):
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**SECTION 3: CHILD AND FAMILY SERVICES CONTACT INFORMATION**

Authority: <input type="checkbox"/> General <input type="checkbox"/> First Nations of Northern MB <input type="checkbox"/> First Nations of Southern MB <input type="checkbox"/> Métis			
CFS Agency:		CFS Worker:	
Phone:		Fax:	
Address:		City/Town:	Postal Code:
Signature:		Date of Request:	

**SECTION 4: TIMEFRAME FOR PROVIDING INFORMATION**

<input type="checkbox"/> IMMEDIATELY	<input type="checkbox"/> WITHIN 2 WEEKS	<input type="checkbox"/> WITHIN 30 DAYS
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**SECTION 5: INFORMATION IS BEING SOUGHT ON THE FOLLOWING INDIVIDUAL(S) CHECKED BELOW:**

<input type="checkbox"/>	Mother's Last Name:		First:	Middle:
	PHIN:		Registration No.:	D.O.B.:
	Address:		City/Town:	Postal Code:
<input type="checkbox"/>	Father's Last Name:		First:	Middle:
	PHIN:		Registration No.:	D.O.B.:
	Address:		City/Town:	Postal Code:
<input type="checkbox"/>	Other Person - Last Name:		First:	
	<input type="checkbox"/> M <input type="checkbox"/> F	PHIN:	Registration No.:	D.O.B.:
	Address:		City/Town:	Postal Code:

<input type="checkbox"/>	Child 1 Last Name:		First:	<input type="checkbox"/> in care <input type="checkbox"/> not in care
	<input type="checkbox"/> M <input type="checkbox"/> F	PHIN:	Registration No.:	D.O.B.:
<input type="checkbox"/>	Child 2 Last Name:		First:	<input type="checkbox"/> in care <input type="checkbox"/> not in care
	<input type="checkbox"/> M <input type="checkbox"/> F	PHIN:	Registration No.:	D.O.B.:
<input type="checkbox"/>	Child 3 Last Name:		First:	<input type="checkbox"/> in care <input type="checkbox"/> not in care
	<input type="checkbox"/> M <input type="checkbox"/> F	PHIN:	Registration No.:	D.O.B.:
<input type="checkbox"/>	Child 4 Last Name:		First:	<input type="checkbox"/> in care <input type="checkbox"/> not in care
	<input type="checkbox"/> M <input type="checkbox"/> F	PHIN:	Registration No.:	D.O.B.:

#### SECTION 6: PERSONAL HEALTH INFORMATION BEING REQUESTED

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

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#### SECTION 7: DISCLOSING TRUSTEE'S INFORMATION

Disclosing Employee:		Phone:
Position:		Fax:
<input type="checkbox"/>	Requested information provided.	<input type="checkbox"/> By phone: <b>HARDCOPY FOLLOW-UP REQUIRED</b> <input type="checkbox"/> By mail <input type="checkbox"/> By courier <input type="checkbox"/> By fax <input type="checkbox"/> Pickup by authorized person
<input type="checkbox"/>	Requested information provided <b><i>in part</i></b> .	Explanation:
<input type="checkbox"/>	Requested information <b><i>not</i></b> 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 MHHS at 204-788-6612 or by email at [PHIAinfo@gov.mb.ca](mailto:PHIAinfo@gov.mb.ca).*