CONTACT INFORMATION

First name: ______________________ Last name: ______________________

Phone: ______________________ Email: ______________________

REQUEST INFORMATION

How would you like to access the records?

◯ Email—ensure email field is filled out above

◯ Mail

Address: ______________________

City: ______________ Province: ______________ Postal code: __________

Describe the records you are requesting—be as specific and detailed as possible.

Note: If you are requesting personal information, provide the full name of that person and any other names or identifiers used previously. If you are requesting someone else's personal information, attach either that person's signed consent for disclosure or proof of authority to act on their behalf; information will not be provided without signed consent or proof of authority.

Date range of records: ______________________

Provide any additional information (e.g. CPSID, file number, reference number, etc.) that may apply.

SIGN-OFF

Signature: ______________________ Date: ______________

Please return this form by:

MAIL Records, Information and Privacy
College of Physicians and Surgeons of BC
300–669 Howe Street
Vancouver BC V6C 0B4

FAX 604-733-3503

EMAIL privacy@cpsbc.ca

Personal information on this form is collected under the *Freedom of Information and Protection of Privacy Act*, RSBC 1996, c.165 and will be used only for the purpose of responding to your request. If you have any questions about the collection or use or disclosure of this information, please contact the director, records, information and privacy for the College of Physicians and Surgeons of British Columbia at 300–669 Howe Street, Vancouver, BC, V6C 0B4 or by email at privacy@cpsbc.ca.