ALBERTA MEDICAL ASSOCIATION

# Request to Access Information

**Personal information you provide below will only be used to complete your access to information request. This form must be completed before information will be released.**

| Title (optional) | Last Name | Middle Initials | First Name |
|---|---|---|---|
| | | | |

| AMA Member Number | Email Address |
|---|---|
| | |

| Name of Company or Organization (*if applicable*) |
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| Mailing Address | Street/Avenue | City | Province | Postal Code |
|---|---|---|---|---|
| | | | | |

| Daytime Telephone Number | Evening Telephone Number | Fax Number |
|---|---|---|
| (  ) | (  ) | (  ) |

**A. What information are you requesting?**

☐ Your own personal information

☐ General information about the Alberta Medical Association for historical or research purposes

**B. Do you wish:** ☐ a copy of the record? ***OR*** ☐ to examine the record?

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**C. Please specify the records you want to access.** Provide us with as much detail as possible.

**i.** Note if you want access to your own personal information and have recently moved or changed your name. You must provide proof of your identity before you will receive records containing your personal information.

**ii.** If you want to access another individual's information, you *must* attach proof that you may legally act for that individual (e.g., power of attorney, guardianship or trusteeship).

**iii.** Note if you want to access information related to a specific department, program, member benefit or for research reasons.

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**D. Specify the time period of the records.**

E.g., To access records from May 15, 2006 - December 31, 2009, enter those dates. To access records from September 2000 to present, enter "September 2000 to present."

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E. Please sign and date this form and send it to the Privacy and Records Advisor, Alberta Medical Association, 12230 106 Avenue NW, Edmonton Alberta T5N 3Z1.

| **Signature** | **Date** |
|---|---|
| | |

**For Office Use Only**

| **Date Received** | **Comments** |
|---|---|
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