Pharmaceutical Information Program

Application for Disclosure to Individual

Form 1

Pharmaceutical Information Program
PO Box 2000
Charlottetown, PE C1A 7N8

Personal information on this form is collected under the *Pharmaceutical Information Act* and Regulations. This information is required in order to process your application for disclosure of information. If you have any questions about this collection of personal information, you may contact the Director of the Pharmaceutical Information Program.

Name (Last name, given name)	**Provincial Health Number** ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	
Mailing address Province Postal code	**Date of birth** --------/---------/--------- day / month / year	**Gender** ☐ male ☐ female
Telephone number	**Current PhIP password** (for office use only) ☐ ☐ ☐ ☐ ☐ ☐	

Identification (attach copy)

☐ birth certificate ☐ drivers licence ☐ (other)_____

If history is required for person other than applicant:

Parent/Guardian's name Telephone number

Mailing address

I am requesting:

☐ medication history, including the generic drug name, strength, dosage form, quantity, date filled, pharmacy, prescriber for the following calendar year(s)_____

☐ access history, including date of access, name of pharmacy, pharmacist, prescriber for the following calendar years_____

☐ I understand that there is a fee associated with my information request. The fee is $10 per calendar year.

☐ **I understand the information requested above will be sent to me in the regular mail.**

Date	Signature

For Office Use Only

☐ fee paid _____ calendar years @ $10 per year = $_____

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