Request No: _____
Request Code: _____

FREEDOM OF INFORMATION AND
PROTECTION OF PRIVACY

REQUEST FOR ACCESS TO RECORDS

NAME OF PUBLIC BODY TO WHICH YOU ARE DIRECTING YOUR REQUEST

☐ Peace River Regional District ☐ Peace River Regional Hospital District

YOUR NAME

Last Name	First Name	Middle Name

YOUR ADDRESS

Street, P.O. Box, RR No.	City/Town	Province/Country	Postal Code

YOUR TELEPHONE/FAX NUMBER(S)

Day Phone No.	Alternate Phone No.	Day Fax No.
( )	( )	( )

DETAILS OF REQUESTED INFORMATION

Information requested. (Please describe the records you are requesting. Be as specific as possible, as this will assist the request process. Attach a separate sheet if the space below is not sufficient. Please specify any reference or file number(s), if known.

Are you requesting access to another person's personal information? ☐ YES ☐ NO
(If so, please attach, as appropriate:)
a) That person's signed consent for disclosure, or
b) Proof of authority to act on that person's behalf.

Preferred method of Access to Records	**Your signature**	**Date Signed** YR	MO	DAY
☐ Examine Original ☐ Receive Copy				

FOR PUBLIC BODY USE ONLY

Date received:	Request Category	☐ Access to General Information (ARCS 292-30/_____)	☐ Access to Personal Information (ARCS 292-30/_____)

Name of Public Body Receiving Request:

You may make a request for access to records without using this form, provided you do so in writing.
Personal information contained on this form is collected under the *Freedom of Information and Protection of Privacy Act* and will be used only for the purpose of responding to your request.