

*Vision: Optimal health for expectant mothers and the infants that are born each year in Alberta*

### Request for Data from the Alberta Perinatal Health Program

Name and Title of the Individual Making the Request: \_\_\_\_\_

Organization the Requesting Individual Represents: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Specific Information / Variables Required: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Time Frames being Requested: \_\_\_\_\_

Purpose of Inquiry: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Intended Use of the Information: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date when the Data are Required: \_\_\_\_\_

#### **I hereby agree to the following conditions:**

1. To comply with the Health Information Act and regulations made under the Act.
2. Data provided through this request will be used only for the purpose for which it was approved.
3. Data provided will be used by the undersigned applicant only, unless otherwise stated in the request.
4. The data must be used for the purpose stated and be reported in the appropriate context in which it was provided.
5. The undersigned shall take responsibility for his/her own interpretation of the data. The Alberta Perinatal Health Program will provide the undersigned with definitions and limitations of the data upon its release.
6. The Alberta Perinatal Health Program will be acknowledged as the source of data.
7. There may be a charge for the data. This is dependent upon the time frame in which the data is required, the amount of time required to retrieve the data, the amount of data requested, etc. You will be notified if a charge is applicable.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant Signature

#### **South Office**

Suite 310, South Tower, Foothills Medical Centre  
1403 – 29 Street NW, Calgary, AB T2N 2T9  
Tel: (403) 944-1242 Fax: (403) 944-1243  
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#### **North Office**

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