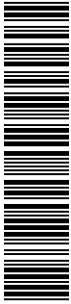




**Request for Correction to Personal Health Information**

<b>1. Patient Contact Information</b>		
<b>Name</b>	Date of Birth (DD/MM/YYYY)	Medical Record Number
<b>Address</b>		<b>Health Card #</b>
Phone # (Best Daytime)		Alternate #
If you're the patient's substitute decision-maker (SDM), please provide your contact information below, as well as copies of relevant documentation that provide your authority as a substitute decision-maker.		
<b>Name</b>	Phone # (Best Daytime)	
<b>Relationship to Patient</b>		
<b>Address</b>		
<b>2. Correction Request</b>		
Please provide, in detail, a description of the information that you are requesting to be corrected. Please include the date of visit, type of visit (i.e. inpatient admission or outpatient clinic visit) and/or account number, if possible.		
_____		
_____		
_____		
_____		
_____		
Please provide the reason the information is incomplete or inaccurate and the information necessary to enable the correction of the personal health information.		
_____		
_____		
_____		
_____		
_____		
Would you like us to give notice of the correction(s), to the extent reasonably possible, to others to whom we have disclosed the incorrect information? (We will only do so if this notice will affect your health care or otherwise benefit you.) <input type="checkbox"/> Yes <input type="checkbox"/> No		
_____ Patient/Substitute Decision Maker Signature		_____ Date
_____ Print Name		





### Request for Correction to Personal Health Information (continued)

Patient Name \_\_\_\_\_

#### 3. Correction Request Response (For Internal Use Only)

- Correction(s) made
- Correction(s) not made
- Refusal letter (with reasons) sent
- Statement of Disagreement attached to record
- Other: \_\_\_\_\_
- Date of Response \_\_\_\_\_ (DD/MM/YYYY)

List names, contact information and comments of any individuals consulted:

If correction was not made, provide reasons:

If an extension to the correction request response was required, please indicate

Date of Extension \_\_\_\_\_

Reason for Extension \_\_\_\_\_

Date Patient Notified of Extension \_\_\_\_\_

List name of those to whom a notice of correction has been sent:

Processed by:

Signature \_\_\_\_\_ Name (print) \_\_\_\_\_ Title \_\_\_\_\_

*All information provided on this form will be used and disclosed in compliance with the Personal Health Information Protection Act.*

