Oak Valley Health

381 Church Street P.O. Box 1800
Markham, Ontario L3P 7P3
Phone: (905) 472-7373 ext. 6216
Fax: (905) 472-7381

Request for Correction to Personal Health Information

1. Patient Contact Information

Name	Date of Birth (DD/MM/YYYY)	Medical Record Number
Address		**Health Card #**
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.

Name	Phone # (Best Daytime)
Relationship to Patient	
Address	

2. Correction Request

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.) ☐ Yes ☐ No

Patient/Substitute Decision Maker Signature

Date

Print Name

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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.