

## REQUEST FORM FOR CORRECTION TO PERSONAL HEALTH RECORD

### Information and Instructions

We will correct health record information if it is demonstrated, to our satisfaction, that the record is incorrect or incomplete for the purpose for which we collect, use or disclose the information.

**Exception:** A health information custodian is not required to correct a record if it consists of a professional opinion or observation that a custodian has made in good faith about the individual. *Personal Health Information Protection Act, 2004, s. 55 (9) (b)*

We will make every effort to respond to your request in a timely fashion.

**Please complete Parts A and B of this Form.** Part C is for our internal use.

Information about our privacy practice available on our website: [www.stjoes.ca/privacy](http://www.stjoes.ca/privacy)

### PART A: REQUESTOR INFORMATION

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Initials: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Date of Birth (yyyy/mm/dd): \_\_\_\_\_ Hospital ID Number: \_\_\_\_\_

If you are a substitute decision-maker\*, your contact information:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Initials: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

\*Note: Include copies of documents that provide your authority as a substitute decision-maker.

### PART B: CORRECTION REQUEST

1. List or attach the correction requested, with reasons for the correction.

Requested Correction	Reason(s) for Correction

2. How do you wish to receive notice of the correction (i.e. in writing, by telephone)?

\_\_\_\_\_

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### PART B: CORRECTION REQUEST

3. Would you like us to give notice of the correction, 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

Signature: \_\_\_\_\_ Printed Name: \_\_\_\_\_

Title: \_\_\_\_\_ Date (yyyy/mm/dd): \_\_\_\_\_

### PART C: CORRECTION REQUEST RESPONSE (For Internal Use Only)

- Correction made
- Correction not made
- Refusal letter (with reasons) sent
- Statement of Disagreement attached to record
- Date of Response (yyyy/mm/dd): \_\_\_\_\_

1. List names, contact information and comments of any individuals consulted

\_\_\_\_\_

\_\_\_\_\_

2. If correction was not made, provide reasons:

\_\_\_\_\_

\_\_\_\_\_

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

Date of Extension (yyyy/mm/dd)	Reason for Extension	Date Patient Notified of Extension (yyyy/mm/dd)

4. Notice of correction provided to others to whom incorrect information was disclosed.

List names:

\_\_\_\_\_

\_\_\_\_\_

5. Processed by:

Signature: \_\_\_\_\_ Printed Name: \_\_\_\_\_ Title: \_\_\_\_\_