Request for Correction to Personal Health Information

PART A: YOUR INFORMATION

Patient Contact Information

SURNAME ____________________ GIVEN NAME ____________________ INITIALS ____________________

MAILING ADDRESS ____________________ CITY ____________________ PROVINCE ____________________ POSTAL CODE ____________________

TELEPHONE (Home) ____________________ TELEPHONE (Work) ____________________ DATE OF BIRTH ____________

HEALTH CARD NUMBER ____________________ HOSPITAL MRN ____________________

Substitute Decision Maker Contact Information (include copies of documents that provide your authority as a substitute decision-maker)

SURNAME ____________________ GIVEN NAME ____________________ INITIALS ____________________

MAILING ADDRESS ____________________ CITY ____________________ PROVINCE ____________________ POSTAL CODE ____________________

TELEPHONE (Home) ____________________ TELEPHONE (Work) ____________________

PART B: CORRECTION REQUEST

Please list or attach a detailed description of the personal health information to which access has been granted and you are requesting to be corrected, the reasons that the personal health information is incomplete or inaccurate and the information necessary to enable the correction.

____________________________ ____________________
SIGNATURE PRINT NAME

DATE ____________

ID VERIFIED ☐

Personal information on this form is collected and used for the purpose of responding to your request, pursuant to the Personal Information Protection Act. For questions about this form or our privacy practices, please contact the Office of Access & Privacy at privacy@mackenziehealth.ca
PART C: FOR INTERNAL USE

☐ CORRECTIONS MADE IN FULL

☐ CORRECTIONS MADE IN PART

☐ CORRECTIONS REFUSED

☐ STATEMENT OF DISAGREEMENT ATTACHED

DATE RECEIVED: ____________________

LIST/ATTACH NAMES, CONTACT INFORMATION & COMMENTS OF INDIVIDUALS CONSULTED:

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IF CORRECTION NOT MADE, PROVIDE REASON:

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DATE NOTIFICATION SENT ____________________ PROCESSED BY ____________________