Request for Correction to Personal Health Information

Based on the *Personal Health Information Protection Act, 2004*

1235 Wilson Avenue, Toronto, ON M3M 0B2
Phone: 416-242-1000 ext. 82300
Fax: 416-242-1085

Under the *Personal Health Information and Protection Act* (*PHIPA*), individuals may request that their health record be corrected if they believe that it is inaccurate or incomplete for the purposes for which the custodian has collected, uses or has used the information. We will only correct documentation if it is demonstrated, to our satisfaction, that the record is not correct or complete for said purposes. If your request is refused, you are entitled to prepare a concise Statement of Disagreement that will become part of your health record at Humber River Hospital.

Instructions

Please complete **PART A and B** of this Form.

Once completed, please submit this form by one of the following methods:

(1) In person to the Health Information Services department (3rd floor of the hospital)

(2) By mail: Humber River Hospital – Privacy Office, 1235 Wilson Avenue, Toronto, ON M3M 0B2

(3) By fax: 416-242-1085

(4) By e-mail: privacy@hrh.ca

PART A: PATIENT INFORMATION Medical Record Number: _____

Patient Name: _____ Date of Birth: _____
LAST NAME *FIRST NAME* *(DD/MM/YYYY)*

Address: _____
STREET ADDRESS *CITY* *PROVINCE* *POSTAL CODE*

Phone Number: _____ E-mail: _____

TO BE COMPLETED ONLY IF SUBSTITUTE DECISION MAKER (SDM) IS REQUESTING CORRECTION

SDM Name: _____ Relationship to Patient: _____
LAST NAME *FIRST NAME*

Address: _____
STREET ADDRESS *CITY* *PROVINCE* *POSTAL CODE*

Phone Number: _____ E-mail: _____

PART B: CORRECTION REQUEST

1. Please describe or attach the correction requested, with **reasons** for the correction.

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2. How do you wish to receive notice of the completed change? Please check **only one**:

☐ In writing ☐ By telephone ☐ By e-mail

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 of Patient or SDM: _____ Date: _____
(DD/MM/YYYY)

Signature of Witness: _____ Date: _____
(DD/MM/YYYY)

For witnesses that are not HRH staff: The witness signature must be a neutral third party, who does not benefit from signing this legal document. The witness must be capable individual who is 16 years or older and must be present and actually see the patient sign the document.