

## 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 not correct or complete for the purpose for which we collect, use or disclose the information. We will make every effort to respond to your request in a timely fashion. Please complete this form and return to:

Manager of Health Information Services  
Health Sciences North | Horizon Santé-Nord  
Ramsey Lake Health Centre  
41 Ramsey Lake Road, SUDBURY, Ontario P3E 5J1  
Facsimile (705) 523-7318

### **PART A: REQUESTOR INFORMATION**

#### **Patient Contact Information:**

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

Mailing Address \_\_\_\_\_

Telephone Number \_\_\_\_\_ Date of Birth \_\_\_\_\_ Hospital ID Number \_\_\_\_\_

If you are a substitute decision-maker (SDM), 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**

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

Requested Correction	Reasons for Correction

How do you wish to receive notice of the correction?      In writing      By telephone

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

DATE: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_ NAME (print) \_\_\_\_\_

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

Corrections made	Corrections not made
Patient or SDM notified of correction in writing or by telephone	Refusal letter (with reasons) sent Statement of Disagreement attached to record
Date of Response:	

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

<b>Name(s)</b>	
<b>Contact Information</b>	
<b>Comments</b>	

If correction was not made, provide reason. Choose appropriate reason from below:

- D The information was not made by this clinician/institution
- D We believe that the request for correction is frivolous, vexatious or made in bad faith
- D The (patient or SDM) has failed to demonstrate that the record is not correct or complete
- D The (patient or SDM) has not given the information needed to make the correction
- D The information forms part of the professional opinion or observation which was made in good faith

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

Date of Extension	Reason for Extension	Date Patient Notified of Extension

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

**List names:**

<b>Name(s)</b>	
<b>Contact Information</b>	