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Request Correction to Personal Health Information Form

Affix Patient Label

☐ SCS ☐ NFS ☐ WS ☐ FES ☐ PCS

Health Records / Privacy Use Only

Date Received: _____ (dd/mm/yyyy) By: _____ Staff Member Name

RETURN ADDRESS
Privacy / FOI Office
Niagara Health, St. Catharines Site
1200 Fourth Avenue, St. Catharines, ON L2S 0A9
Tel – 903-578-4647 ext. 44475
Fax – 905-397-1929

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 parts A and B of this Form.** Part C is for our internal use.

PART A: Requestor Information

_____ Patient's Last Name
_____ First Name
_____ Middle Name or Initial

Mailing Address: _____

_____

_____ Telephone Number
_____ Date of Birth (dd/mm/yyyy)
_____ Health Card Number

If you are a substitute decision maker (SDM), please provide your contact information below.
Note: Include copies of documents to provide your authority as SDM.

_____ Last Name
_____ First Name
_____ Middle Name or Initial

Mailing Address: _____

_____

_____ Telephone Number

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PART B: Correction Request

1. Identify incorrect or incomplete information and state correction (please be specific)

Name of Document (Consultation, History and Physical, etc.)	Date of Document and Author of Document	Incorrect or Incomplete Information	Corrected Entry – Information Should Say

2. Reason for Correction(s): _____

_____

_____

_____

_____

3. Would you like us to give notice of the correction, to the extent reasonably possible, to others to whom we have disclosed the information? (We will try to do this if this correction affects your health care or otherwise benefits you).

☐ Yes ☐ No

Patient / SDM Signature: _____

Print Name: _____

Relationship to Patient (if applicable): _____

Date (dd/mm/yyyy): _____ Witness: _____

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PART C: Correction Request Response (For NH Use Only)

☐ Correction Made — Date (dd/mm/yyyy) _____

☐ Correction Refused — Date (dd/mm/yyyy) _____

☐ Privacy Refusal Letter / Statement of Disagreements to Patient / SDM — Date (dd/mm/yyyy) _____

☐ Patient Response Received — Date (dd/mm/yyyy) _____

1. If correction refused, provide reason(s) and **sign:**

_____

_____

_____

_____

_____

_____

_____

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_____

2. If an **extension for correction request response** was required, please indicate:

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

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

List Names	**Date Sent** (dd/mm/yyyy)
_____	_____
_____	_____
_____	_____

Exceptions:

Name: _____ Reason: _____

Name: _____ Reason: _____

Name: _____ Reason: _____

4. Statement of Disagreement received from patient / SDM, and **attached to chart** on:

Date (dd/mm/yyyy)	By	Title