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STATEMENT OF DISAGREEMENT

Patient Name:	Date of Birth: (dd/mm/yyyy)	Health Card #:				
Substitute Decision-Maker Name:	Relationship:					
Address:		Telephone:				
I have reviewed my personal health information contained within the record. I h made. Therefore, under section 55(11) of the of Disagreement' be filed in the Medical Reconstruction of Disagreement.	ave been advised by Mackenzie Health that e Personal Health Information Protection A	my requested correction with not be				
(State details of the information in disagreement, including date, time and author)						
☐ I request that this Statement of Disagreement be added to my personal health information/record whenever it is disclosed.						
Signature of Patient or Substitute Decision-N	Maker Date (dd/mm/yyyy)				
Hospital Use Only						
Date Received:dd/mm/yyyy	Date Pub	lished: dd/mm/yyyy				





Cortellucci Vaughan Hospital 3200 Major Mackenzie Drive West, Vaughan ON L6A 4Z3 905-417-2000

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