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.

ID VERIFIED ☐

SIGNATURE ____________ PRINT NAME ____________ DATE ____________

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 question about this for or our privacy practices, please contact the Office of Access & Privacy at privacy@mackenziehealth.ca

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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