

Correction of Personal Health Information Request

Information and Instructions:

We will correct personal health information (PHI) if it is satisfactorily demonstrated to be inaccurate or incomplete. We will not correct a record if the Hospital did not create the record and does not have sufficient knowledge, expertise and authority to correct it, or the record consists of a professional opinion or observation made in good faith.

We will respond to your request within 30 days indicating if the Hospital is granting or denying the request or extending the deadline for responding.

Please complete Parts A and B of this form. Part C is for our internal use. For information about our privacy protection practices, contact our Information and Privacy Office at 416-762-7316 x 2117 or at info.privacy@runnymedehc.ca.

PART A: Requestor Information

Patient Contact Information:

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss.

Last Name

First Name

Hospital Master Chart No.

Date of Birth

Substitute Decision-Maker Contact Information (if applicable):

Last Name

First Name

Relationship

Telephone Number

Mailing Address

Note: Please provide copies of documents that provide your authority as a substitute decision-maker.

PART B: Access Request

- Please list or attach the correction requested, with reasons for the correction.

Requested Correction

Reasons for Correction

2. How you would prefer to receive notice of the correction? Please check off.

☐ By phone

☐ In writing

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

Name (print)

Date

Please forward this completed form to the Health Information Services Department

~ To be completed by Information and Privacy Office ~

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

☐ Correction made

☐ Correction not made

☐ Refusal letter (with reasons) sent

☐ Statement of Disagreement attached to record

☐ Date of response _____

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

_____	_____
_____	_____
_____	_____

2. If correction was not made, provide reasons:

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

Date of Extension

Reason for Extension

Date Patient Notified of Extension

4. Notice of correction provided to others to who incorrect information was disclosed. List names:

Completed by:

Signature

Name (print)

Title

Date

Signature

Name (print)

Title

Date