CHATHAM-KENT Health Alliance

Request for Correction to Personal Health Record Form

The Personal Health Information Protection Act (PHIPA) provides patients with the right to make a Request for Correction. Your record of personal health information will be corrected if you can demonstrate, to the CKHA's satisfaction, that your record is inaccurate for the purpose that CKHA uses this information. You must also provide the information necessary to correct the record.

Exception: As per PHIPA, 2004, s. 55 (9)(b), a health information custodian is not required to correct a record if it consists of a professional opinion or observation that a custodian had made in good faith about the individual. Please note that Ontario law does not permit hospitals to delete information from a patient's health record, even if that information is determined to be incorrect or incomplete. Instead, incorrect information is labelled as such and, in keeping with Ontario law, it continues to remain accessible within that record.

Please complete Parts A, B and C of this form, print, sign and submit to the Release of Information Office. Part D is for our internal use. Page 4 (Appendix A) provides more space to list additional corrections if needed.

Part A: Patient Information

Legal Last Name | Legal First Name | Preferred / Chosen Name

Date of Birth (MM/DD/YYYY) | Mailing Address | City | Province

Postal Code | Phone Number | Email Address (optional)

Part B: Correction Request

1. **See page 2** to list or attach the correction request, with reasons for the correction.
2. How do you wish to receive notice of the correction? ☐ In Writing ☐ By Telephone ☐ By Email
3. Would you like us to give notice of this 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

Correction Consent:

Patient/Substitute Decision Maker Signature* | Please Print Name | Relationship to Patient

Witness Signature | Please Print Name | Date (MM/DD/YYYY)

*** If you are a substitute decision-maker making the request, please provide your contact information:**

Mailing Address | Phone Number

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Part C: Details of Correction Request

Patient Name (Last Name, First Name) Date of Birth (MM/DD/YYYY)

Information and Instructions: In this section, please describe the correction you are requesting. Clearly state what information in your health record you believe is inaccurate or incomplete. Please also explain why you believe the correction should be made. You may attach additional details or documentation that supports your request for the correction. **If more space is needed to list additional corrections, see page 4.**

Please indicate who provided you with a copy of the document(s) (select one option below):

☐ CKHA ☐ ConnectMyHealth ☐ Other (describe)

What information is incorrect or incomplete?

Name of document	Date of document (based on date of visit) (MM/DD/YYYY)	Who is the author of the document?	List the information that is incorrect or incomplete:

Please explain why you believe the correction(s) listed above should be made:

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Part D: Response to Access Request (for Internal Use Only)

Patient Name (Last Name, First Name)

Date of Birth (MM/DD/YYYY)

☐ Correction Made ☐ Correction Not Made ☐ Refusal Letter (with reasons) sent

Date of Response:

☐ Statement of Disagreement attached to record

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

2. If correction was not made, provide reason(s):

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

   Date of Extension:

   Date Requestor Notified:

   Reason for Extension:

4. Notice of correction provided to others to whom inaccurate information was disclosed. List names:

Processed By Signature

Print Name/Title

Date (MM/DD/YYYY)

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Appendix A: Details of Correction Request ***(complete only if needing more space in addition to page 2)***

Patient Name (Last Name, First Name) Date of Birth (MM/DD/YYYY)

Information and Instructions: In this section, please describe the correction you are requesting. Clearly state what information in your health record you believe is inaccurate or incomplete. Please also explain why you believe the correction should be made. You may attach additional details or documentation that supports your request for the correction.

Please indicate who provided you with a copy of the document(s) (select one option below):

☐ CKHA ☐ ConnectMyHealth ☐ Other (describe)

What information is incorrect or incomplete?

Name of document	Date of document (based on date of visit) (MM/DD/YYYY)	Who is the author of the document?	List the information that is incorrect or incomplete:

Please explain why you believe the correction(s) listed above should be made: