Health Sciences North
Horizon Santé-Nord

REQUEST FORM FOR CORRECTION TO PERSONAL HEALTH RECORD

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 this form and return to:

Manager of Health Information Services
Health Sciences North | Horizon Santé-Nord
Ramsey Lake Health Centre
41 Ramsey Lake Road, SUDBURY, Ontario P3E 5J1
Facsimile (705) 523-7318

PART A: REQUESTOR INFORMATION

Patient Contact Information:

Last Name_____First Name_____Initials_____

Mailing Address_____

Telephone Number_____Date of Birth_____Hospital ID Number _____

If you are a substitute decision-maker (SDM), your contact information:

Last Name_____First Name_____Initials _____

Mailing Address_____

Telephone Number _____

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

PART B: CORRECTION REQUEST

List or attach the correction requested, with reasons for the correction.

Requested Correction	Reasons for Correction

How do you wish to receive notice of the correction? ☐ In writing ☐ By telephone

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

DATE:_____SIGNATURE:_____NAME (print) _____

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PART C: CORRECTION REQUEST RESPONSE (For Internal Use Only)

☐ Corrections made	☐ Corrections not made
☐ Patient or SDM notified of correction ☐ in writing ☐ or by telephone	☐ Refusal letter (with reasons) sent ☐ Statement of Disagreement attached to record
Date of Response:	

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

Name(s)	
Contact Information	
Comments	

If correction was not made, provide reason. Choose appropriate reason from below:

☐ The information was not made by this clinician/institution
☐ We believe that the request for correction is frivolous, vexatious or made in bad faith
☐ The (patient or SDM) has failed to demonstrate that the record is not correct or complete
☐ The (patient or SDM) has not given the information needed to make the correction
☐ The information forms part of the professional opinion or observation which was made in good faith

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

Date of Extension	Reason for Extension	Date Patient Notified of Extension

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

Name(s)	
Contact Information	