Hamilton Health Sciences

Internal Use Only

Date Received: _____

Hamilton Health Sciences – King West
P.O. Box 2000, Hamilton, Ontario L8N 3Z5
Attention: Privacy and Freedom of Information Office
Tel - 905-521-2100 ext 75122
Fax - 905-577-8474

Hamilton Health Sciences
CORRECTION REQUEST FORM

Information & Instructions:

As stated in the Personal Health Information Act, 2004 (PHIPA) 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 Parts A & B of this form. Part C is for our internal use.

Part A: Requester Information:

_____ _____ _____
Patient's Last Name First Name Middle Name or Initial

_____
Mailing Address

_____ _____ _____
Telephone Number Date of Birth Ontario Health Card Number

If you are a substitute decision maker, please provide your contact information.

_____ _____ _____
Last Name First Name Middle Name or Initial

_____
Mailing Address

_____
Telephone Number

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

1. What information is incorrect or incomplete?

Name of Document (Consultation, History & physical, etc.)	Date of Document	Who is the author of the document?	Which information is incorrect or incomplete?

2. Reason for Correction:

_____

_____

_____

_____

_____

3. Would you like us to give notice of the correction, to the extent reasonably possible, to others to whom we have disclosed the information? (We will only do so if this correction affects your health care or otherwise benefits you)

☐ Yes ☐ No

Signature _____

Print Name _____

Relationship to Patient (if applicable) _____

Date _____

PLEASE RETURN TO THE ADDRESS ON THE FIRST PAGE

Part C: Correction Request Response (For Privacy Office Use Only):

☐ Correction Made

☐ Correction Not Made

☐ Refusal Letter Sent

☐ Date of Response

1. List Names, Contact Info and Comments of any individuals consulted

_____

_____

_____

2. If correction not made, provide reasons:

_____

_____

_____

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

Date of Extension	Reason for Extension	Date Patient Notified of Extension

4. Notice of correction provided to others to whom incorrect information was disclosed.

List Names: Date:

_____ _____

_____ _____

_____ _____

Exceptions:

Name _____ Reason _____

Name _____ Reason _____

Name _____ Reason _____

5. A statement of disagreement was received and attached to the chart on:

_____.
Date