**REQUEST TO CORRECT PERSONAL HEALTH INFORMATION**

I,________________________________________ request that ____________________________________________

(Name of Applicant) (Name of Facility/Program)

make a correction to the personal health information of:

Patient Name: ____________________________________________________________________________________

Last Name First Name(s)

Address: ________________________________________________________________________________________

Date of Birth: ____________________________________ PHIN: ____________________________________________

Phone Number: Home ____________________________Work ___________________________________________

Person requesting correction (if different from above):

Name: __________________________________________________________________________________________

Last Name First Name(s)

Relationship to Patient: ____________________________________________________________________________

(or legal authority for request)

Address: ________________________________________________________________________________________

Phone Number: Home____________________________________ Work ___________________________________

Date and Where Service Provided: ____________________________________________________________________

(Facility/Department/Program/Clinic/Service)

Correction Requested (use additional pages as required): ________________________________________________

________________________________________________________________________________________________

________________________________________________________________________________________________

Reason for Request (Optional)

Signature: _______ ____________________________________________ Date: __________________________

You will be contacted within 30 days of the receipt of your request, to inform you whether we will make the requested corrections to your personal health information or inform you of our refusal to make the corrections. If your request is refused, it is your right to add a statement of disagreement to the record and to make a complaint about the refusal under Part 5 of the *Personal Health Information Act.*

**To be filled out by Privacy Officer (or designate):**

**DISPOSITION**

Date Request Received: ______________________________

Signature of Recipient: ______________________________

Name and Position: ______________________________

**Disposition of Request:**

__________ Request Approved

__________ Request Denied

**Requestor Notified:** ______________________________

Date

Authorizing Signature: ______________________________

Name and Position: ______________________________

Date: ______________________________

Comments: ______________________________