REQUEST FOR CORRECTION TO PERSONAL HEALTH INFORMATION AND PERSONAL INFORMATION

Please complete Parts A and B and submit to the Regional Privacy Office at 201 Georgian Drive, Barrie ON, L4M 6M2, or via email privacy@headwatershealth.ca, or via fax at 705-797-3110.
For questions or assistance, please contact the Regional Privacy Office at 519-941-2410 ext 2578 or privacy@headwatershealth.ca.

PART A: REQUESTOR INFORMATION *(all sections required – please print clearly)*

Requestor Name:

_____
Last Name First Name Initial

Date of birth:

_____
Patient Name (if different than requestor)

_____
Last Name First Name Initial

Date of birth: _____

Relationship to Patient* (if applicable):

_____

Address:

_____
Street City Province Postal Code

Phone Number: _____ Email Address: _____

** Only the Substitute Decision-Maker can request a correction on behalf of a patient*

PART B: REQUEST DETAILS *(all sections required – please print clearly)*

Please indicate at which hospital the record(s) was created.			
☐ Collingwood General & Marine Hospital	☐ Georgian Bay General Hospital	☐ Headwaters Health Care Centre	☐ Royal Victoria Regional Health Centre
Please provide or attach a detailed description of the record(s) and a description of the requested correction(s). Please include any supporting documentation you may have.			
☐ Request for Correction to Personal Health Information (Personal Health Information Protection Act) ☐ Request for Correction to Personal Information (Freedom of Information and Protection of Privacy Act)			

Note: You will be notified if the correction is not made and you may then request that a statement of disagreement be attached to the record.

PART C: Request Information *(Internal Use Only)*

Date Received:	Request No:	Comments:

STATEMENT OF DISAGREEMENT

Please complete and submit to the Regional Privacy Office at 201 Georgian Drive, Barrie ON, L4M 6M2, or via email privacy@headwatershealth.ca, or via fax at 705-797-3110.
For questions or assistance, please contact the Regional Privacy Office at 705-792-3318 or privacy@headwatershealth.ca.

PART A: REQUESTOR INFORMATION *(all sections required – please print clearly)*

Requestor Name:

_____

Last Name First Name Initial

Date of birth: _____

Patient Name (if different than requestor)

_____

Last Name First Name Initial

Date of birth:

_____

Relationship to Patient* (if applicable):

_____

Address: _____

Street City Province Postal Code

PART B: STATEMENT OF DISAGREEMENT DETAILS *(all sections required – please print clearly)*

I have reviewed my personal health information and/or personal information, or the personal health information and/or personal information of the above patient, and disagree with the information contained within the record. I have been advised that my requested correction will not be made. Therefore, I hereby request that this 'Statement of Disagreement' be filed in the record.

_____ _____

Signature Date

Please provide or attach a detailed description of the information in disagreement, including date, time and author.

PART C: STATEMENT INFORMATION *(Internal Use Only)*

Date Received:	Request No:	Date Published: