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 regionalprivacy@rvh.on.ca, or via fax at 705-797-3110.
For questions or assistance, please contact the Regional Privacy Office at 705-792-3318 or regionalprivacy@rvh.on.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:

Hôpital général de la baie Georgienne
GEORGIAN BAY
General Hospital

STATEMENT OF DISAGREEMENT

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