

**REQUEST FOR CORRECTION TO PERSONAL
HEALTH INFORMATION**

Last Name: _____ First Name: _____
 Date of Birth (DD/MM/YYYY): _____ / _____ / _____
 Health card #: _____
 MRN #: _____
 CSN #: _____
 Affix patient encounter label here/complete all fields if label not available.

PART B: CORRECTION REQUEST

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

Requested Correction	Reasons for Correction

2. How do you wish to receive notice of the correction?

Telephone Mail Encrypted Email Email Address: _____

3. 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

Signature

Print Name

Date

Interpreter: I have done my best to accurately translate this form for the person referred to above, and will not divulge information learned during this review.

Interpreter Name: _____ **Interpreter Signature:** _____

THIS FORM CAN BE MAILED, EMAILED OR FAXED TO THE HEALTH RECORDS DEPARTMENT

Email: ReleaseOfInformation@thp.ca

Mississauga Hospital

100 Queensway West, Mississauga, ON L5B 1B8
 Phone: 905-848-7181 Option 8
 Fax: 905-848-7677

Credit Valley Hospital

2200 Eglinton Ave W, Mississauga, ON L5M 2N1
 Phone: 905-813-1100 Ext. 5885
 Fax: 905-813-4101



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THP use only

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PART C: CORRECTION REQUEST RESPONSE (FOR INTERNAL USE ONLY – RELEASE OF INFORMATION)

1. Status of the Response

- | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Correction made in Entirety
<input type="checkbox"/> Correction Made Partially
<input type="checkbox"/> Correction Withdrawn Not Made | <input type="checkbox"/> Statement of Disagreement Attached to Records
<input type="checkbox"/> Correction Not Made (Refusal Letter with Reason Provided) |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|

2. List Names, Contact information and Comments of any individuals consulted:

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:

5. Response for Correction Provided to requester

Sent via Mail Email Other: _____

6. Processed By:

- All relevant communications with the HCP(s) are attached with the Correction to PHI request

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