North Bay Regional Health Centre

Request for Correction to Personal Health Record

- The North Bay Regional Health Centre will correct personal 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.
- Please complete the information on the front of this form and return the form as indicated below.
- **You will receive a response to your request within 30 days from the date the request was received**

Patient Contact Information:

Last Name ____________ First Name ____________ Middle Name ____________

Mailing Address ____________

Telephone ____________ Date of Birth (DD/MM/YYYY) ____________

If you are a substitute decision-maker (SDM), your contact information

Last Name ____________ First Name ____________ Middle Name ____________

Mailing Address ____________

Telephone ____________ Relationship ____________

Please include copies of documents that provide your authority as the SDM (Example: Power of Attorney, Executor of Estate, etc).

1. Please describe the information you wish to correct, along with the reasons for the correction. Please provide further details in regards to the information you feel is incorrect:
   - o Clinical Content (medical information related to your condition and/or health
   - o Demographic Information (name, sex, address, date of birth)
   - o Other ________________________________
2.

Requested Correction	Reasons for Correction

Date and Author of Information you wish to have corrected (if known):	

How do you wish to receive notice of the correction? (in writing, by telephone)?

____

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? This may include your family physician, specialists or other health care member who were copied on the original note.

☐ Yes

☐ No

____________________ ______________________ ________________

Patient or Substitute Decision Maker Signature | Name (please print) | Date

To be completed by NBRHC staff

Date Correction Request Received (DD/MM/YYYY): ___________________________

Employee's Name: _____________________________________

Employee's Signature: ___________________________________

Please forward your request to:

By Mail:

Manager, Clinical Records
North Bay Regional Health Centre
50 College Drive, Box 2500
North Bay, ON P1B 0A4

By Fax:

705-495-7931
Attention: Manager, Clinical Records or designate

Guidelines for Use:

1. Refer to policy ADM-095 – Access and Corrections to Personal Health Information Records by Patient
2. Patient or SDM to complete form and submit request to Manager, Clinical Records or designate. If SDM provides supplementary documentation to support signing authority, the documentation will remain attached to this request.
3. Manager, Clinical Records or designate to date and sign form upon receipt.
4. Form to be maintained in Correspondence section in Clinical Records department