Student Health and Wellness
t: (807) 343-8361 f: (807) 346-7740

REQUEST FORM FOR CORRECTION TO PERSONAL HEALTH RECORD

Personal Health Information Protection Act

Information and Instructions
We will correct 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. We will make every effort to respond to your request in a timely fashion. Please complete Parts A and B of this Form. Part C is for our internal use.

Once completed, this Form should be forwarded to the **Director, Student Health & Wellness** by one of the following methods:

(1) in person to Student Health and Wellness;
(2) by email: cdangel2@lakeheadu.ca
(3) by mail: UC 1007 - 955 Oliver Rd. Thunder Bay, ON P7B 5E1
(4) by fax: (807) 346-7740

PART A: REQUESTOR INFORMATION

Patient Contact Information:

Last Name _____ First Name _____ Initials _____

Mailing Address _____

Telephone Number _____ Date of Birth _____

If you are a substitute decision-maker, please provide your contact information:

Last Name _____ First Name _____ Initials _____

Mailing Address _____

Telephone Number _____

Note: Include copies of documents that provide your authority as a substitute decision-maker**.**

PART B: CORRECTION REQUEST

(1) List or attach the correction(s) requested, with reasons for the correction(s):

Requested Correction(s)	**Reasons for Correction(s)**

(2) Would you like us to give notice of the correction(s), 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

Requestor's Signature _____ Name (print) _____

Date _____

PART C: CORRECTION REQUEST RESPONSE (**For Internal Use Only**)

- ☐ Correction(s) made
- ☐ Correction(s) not made
- ☐ Refusal letter (with reasons) sent
- ☐ Statement of Disagreement attached to record
- ☐ Other
- ☐ Date of Response _____

(1) List names, contact information and comments of any individuals consulted:

_____
_____
_____

(2) If correction was not made, provide reasons:

_____
_____
_____

(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) List names of those to whom a notice of correction has been sent:

_____
_____
_____

(5) Processed by:

_____	_____	_____
Signature	Name (print)	Title

All information provided on this form will be used and disclosed in compliance with the Personal Health Information Protection Act.