SOMERSET WEST COMMUNITY HEALTH CENTRE

REQUEST TO CORRECT PERSONAL HEALTH INFORMATION

Pursuant to the Personal Health Information Protection Act, 2004

Information and instructions:

The Centre will correct your personal health information, if you can demonstrate that it is incorrect or incomplete for the purpose for which we collect, use or disclose the information. Please complete **Part A** and **B** of this form only. **Part C** is for Centre use. For information about our information practice please contact the Corporate Privacy Officer. Telephone: (613) 238-8210 or email privacyofficer@swchc.on.ca

PART A: Requestor of information:

Patient Name: _____ Date of Birth: _____

Address: _____

_____ Telephone Number: _____

If you are a substitute decision maker:

Name: _____ Telephone Number: _____

Address: _____

_____

PART B: Correction Request:

Please list or attach the corrections requested, with your reasons for requesting the correction:

_____

_____

How do you wish to receive notice of the correction? Please indicate:

☐ In writing ☐ By telephone

Please indicate if you would like the Centre to give notice of the correction to others to whom we have disclosed the incorrect information, but realize that we will only do so if it will affect your health care or otherwise benefit you.

Yes ☐ No

Witness: _____ Signed by:_____
(client or substitute decision maker)

Date: _____ _____
(relationship to the client)

Reviewed December 2020

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PART C: Response to Access Request: *For Centre Use Only*

1. Receipt of Request:

Date Request Received:_____

Date Request Sent to Provider:_____

Date Response Issued:_____

2. Response to Request:

Access request granted
Access request not granted
Access request granted in part only

If access was not granted, specify reason for refusing the request in whole or in part: (*to be completed by provider*)

_____ _____

Provider's Name (Print) Signature of Provider

Extension of Time for Response:

Date of Extension	Reason for Extension	Date Client Notified

Date of Access:

Date of Access	*Indicate what photocopies of personal health information were provided to the client*

Processed By:

_____ _____ _____

Name: (Print) Signature Date

Reviewed December 2020