WOMEN'S COLLEGE HOSPITAL
Health care for women | REVOLUTIONIZED
76 Grenville Street, Toronto, ON M5S 1B2

HEALTH INFORMATION DEPARTMENT REQUEST FOR CORRECTION TO YOUR PERSONAL HEALTH INFORMATION

PATIENT IDENTIFICATION

INFORMATION AND INSTRUCTIONS

Women's College Hospital will make every effort to respond to your correction request in a timely fashion. Personal health information will be corrected upon your request if it is demonstrated, according to the Personal Health Information Protection Act, that the record is inaccurate or incomplete for the purposes for which Women's College Hospital collects, uses, or discloses the information. Please complete Parts A and B of this form. Part C is for our internal use. For further information or clarification, please contact the Release of Information Specialist in the Health Information Department at: 416-323-6098 or you can visit us at 76 Grenville Street, Room P1-208, Toronto, Ontario M5S 1B2 Please note that our general business hours are from Monday to Friday, 8:00am to 4:00pm.

PART A: REQUESTOR INFORMATION

PATIENT CONTACT INFORMATION:

Last name: _____ First name: _____ Initials: _____

Mailing address: _____

Telephone number: _____ Date of birth: _____/___/___
YYYY/MM/DD

Hospital ID number: _____ Health Card Number: _____

If you are a substitute decision-maker, 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. Please describe what you want corrected and include details that will help us locate the record (e.g., dates, name of healthcare provider, etc.).

_____

_____

_____

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PATIENT IDENTIFICATION

2. Include a copy of the correct information.
   - ❑ Yes
   - ❑ No

Print Name: _____ Signature: _____ Date: _____/___/___
YYYY/MM/DD

PART C: RESPONSE TO CORRECTION REQUEST (FOR INTERNAL USE ONLY)

1. INFORMATION REGARDING RECEIPT AND INITIAL REVIEW OF REQUEST

Date request received: _____/___/___
YYYY/MM/DD

2. INFORMATION REGARDING EXTENSION

If an extension to the access request response was required, please indicate:

Date of extension:	Reason for extension:	Date patient notified:
_____/___/___ YYYY/MM/DD		_____/___/___ YYYY/MM/DD

3. INFORMATION REGARDING RESPONSE

Date response issued: _____/___/___
YYYY/MM/DD

- ❑ Correction granted
- ❑ Correction not granted
- ❑ Correction request granted in part

4. PROCESSED BY:

Print Name: _____ Signature: _____ Title: _____