PROVIDENCE Healthcare

Request to Correct Personal Health Information

Pursuant to the Personal Health Information Protection Act, 2004 (PHIPA)

PATIENT/RESIDENT/CLIENT INFORMATION			
Last Name	First Name	Middle Name	
Street Address (No. and Name)			Apt. No.
City	Province/State	Postal Code/ZIP	
Phone No.	Date of Birth (DD/MM/YYYY)	OHIP No.	

REQUESTOR INFORMATION

- ❑ Patient/Resident/Client (Self)
- ❑ Substitute Decision Maker for Personal Care (Please provide *Power of Attorney for Personal Care* document)
- ❑ Executor (please provide *Will* document)

Last Name	First Name	Middle Name	
Street Address (No. and Name)			Apt. No.
City	Province/State	Postal Code/ZIP	
Phone No.	Fax No.		

PERSONAL HEALTH INFORMATION IN QUESTION

Please provide a detailed description of the personal health information to which access has been granted and that you are requesting be corrected, the reason that the personal health information is incomplete or inaccurate and the information necessary to enable the correction of the personal health information.

REQUESTOR SIGNATURE		
Requestor Name (Print)	Requestor Signature	Date (DD/MM/YYYY)

The personal health information contained on this form is collected pursuant to the Personal Health Information Protection Act, 2004 ("The Act") and will be used for the purpose of responding to your request for correction pursuant to section 55 of the Act. Questions about this collection should be directed to the Privacy department at Providence Healthcare.