



**REQUEST FOR CORRECTION TO PERSONAL HEALTH RECORD**

https://www.barcodesinc.com/generator/image.php?code=ROI-1&style=164&type=C39&width=200&height=55&xres=2&font=3[http://www.barcodesinc.com/generator/image.php?code=SP-62&style=164&type=C39&width=200&height=55&xres=2&font=3](http://www.barcodesinc.com/generator/image.php?code=SP-62&style=164&type=C39&width=200&height=55&xres=2&font=3)

*Patient Label*

# Information and Instructions

TEGH 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 TEGH collects, uses or discloses the information. TEGH 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. For information about our privacy protection practices, contact our Privacy Officer at (416) 469-6580, Extension 7781.

## PART A: REQUESTOR INFORMATION

**Patient Contact Information** (complete if addressograph not available**):**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name First Name Initials

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address City/Province Postal Code

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone Number Date of Birth (dd/MMM/yyyy) Health Record Number

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name First Name Initials

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address City/Province Postal Code

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone Number

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

**PART B: CORRECTION REQUEST**

1. List or attach the correction requested, with reasons for the correction.

|  |  |
| --- | --- |
| **Requested Correction** | **Reasons for Correction** |
|  |  |

2. How do you wish to receive notice of the correction

* In writing
* By telephone

3. Would you like TEGH to give notice of the correction, to the extent reasonably possible, to others to whom TEGH has disclosed the incorrect information? (TEGH will only do so if this notice will affect your health care or otherwise benefit you.)

* Yes No

Signature Name (Print) Date

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**PART C: CORRECTION REQUEST RESPONSE**

**(For Internal Use Only)**

*Patient Label*

* Correction made

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name (Reviewed by) Date Request Received (dd/MMM/yyyy)

Comments:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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* Correction not made

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name (Reviewed by) Date Request Received (dd/MMM/yyyy)

Reasons:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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|  |  |
| --- | --- |
| * Refusal letter (with reasons) sent | * Statement of Disagreement attached to record |
|  |  |

1. If an extension to the correction request response was required, please indicate:

|  |  |  |
| --- | --- | --- |
| **Date of Extension**  (dd/MMM/yyy) | **Reason for Extension** | **Date Patient Notified**  (dd/MMM/yyy) |
|  |  |  |

2. Notice of correction provided to others to whom incorrect information was disclosed.

List Names:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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3. Processed by:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Name (Print) Date Request Received (dd/MMM/yyyy)



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