**REQUEST FORM FOR CORRECTION TO PERSONAL HEALTH RECORD**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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. For information about our privacy protection practices, contact the Privacy Officer at:  Lennox & Addington County General Hospital  8 Richmond Park Dr.  Napanee, ON K7R 2Z4  Fax: 613-354-1847  Email: [privacy@lacgh.napanee.on.ca](mailto:privacy@lacgh.napanee.on.ca)  Phone: 613-354-3301 ext. 211 | | | | |
| **PART A: REQUEST FOR INFORMATION**  **Patient Contact Information:**    Last Name First Name Initials    Mailing Address    Telephone Number Date of Birth Hospital ID 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. 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 us to give notice of the correction, 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     Signature Name (print) Title    Date | | | | |
| **PART C: CORRECTION REQUEST RESPONSE (For Internal Use Only)**   * Correction made * Correction not made * Refusal letter (with reason) sent * Statement of Disagreement attached to record * Date of Response  1. List names, contact information and comments of any individuals consulted      1. If correction was not made, provide reasons:      1. If an extension to the correction request response was required, please indicate: | | | | |
|  | **Date of Extension** | **Reason for Extension** | | **Date Patient Notified of Extension** |
|  |  |  | |  |
| 1. Notice of correction provided to others to whom incorrect information was disclosed. List names: 2. Processed by:     Signature Name (print) Title | | | | |