Holland Bloorview
Kids Rehabilitation Hospital

Request for Correction / Amendment of Health Information

Information and Instructions

Holland Bloorview Kids Rehabilitation 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 not correct or complete for the purposes for which Holland Bloorview Kids Rehabilitation Hospital collects, uses, or discloses the information. Please complete **Parts A** and **B** of this form. ***Part C is for our internal use only***.

PART A: REQUESTOR INFORMATION

Patient Contact Information:

_____   _____   _____
Last Name   First Name   Initials

_____
Mailing Address

_____   _____   _____
Telephone Number   Date of Birth (dd/mm/yyyy)   Health Record No.

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

_____   _____   _____
Last Name   First Name   Initials

_____
Mailing Address

_____
Telephone Number

CON AMENDINFO

PART B: CORRECTION REQUEST

Date of Report or Entry to be amended: _____

Title of Report: _____

Author of Report or Entry: _____

Please explain how the report or entry is incorrect or incomplete.

_____

_____

_____

What should the report or entry say to be more accurate or complete?

_____

_____

_____

Would you like this amendment sent to anyone to whom we may have disclosed the information in the past? If so, please specify the name and address of the organization or individual.

_____   _____
             Name   *Address*

_____   _____
             Name   *Address*

_____   _____   _____
      Signature   *Date*   *Relationship to Client*

*NOTE: 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.

CON AMENDINFO

PART C: CORRECTION REQUEST RESPONSE

For Holland Bloorview Kids Rehabilitation Hospital use only:

Date received:_____ Date Complete: _____

Amendment accepted ☐   Amendment denied ☐   New Report Required ☐

Further Instructions: _____

_____

_____   _____   _____
Author's Name & Title   *Date*   *Author's Signature*

_____
Signature- Manager of Health Information Management