ATLAS

☐ TOH General ☐ TOH Civic ☐ TOH Riverside
☐ UOHI ☐ Hawkesbury ☐ Renfrew ☐ SFMH
☐ Other specify: _____

AFFIX LABEL

MRN:

Last name:

First name:

Date of birth:

REQUEST FOR CORRECTION TO THE HEALTH RECORD

Date of request (yyyy/mm/dd): _____

Information and Instructions: The Atlas Alliance Epic Health Information System (HIS) is a tool that connects and contains electronic health records from six (6) hospital organizations. The Atlas Alliance Members ("Member") include The Ottawa Hospital, Hawkesbury and District General Hospital, St. Francis Memorial Hospital, Renfrew Victoria Hospital, the University of Ottawa Heart Institute and the Ottawa Hospital Academic Family Health Team.

The Personal Health Information Protection Act (PHIPA) provides patients with the right to make a Request for Correction. The Member will correct your record of personal health information if you can demonstrate, to the Hospital's satisfaction, that your record is **incomplete or inaccurate for the purpose that the Hospital uses this information.** You must also provide the information necessary to correct the record.

Exception: As per the Personal Health Information Protection Act, 2004, s. 55 (9)(b), a health information custodian is not required to correct a record if it consists of a professional opinion or observation that a custodian had made in good faith about the individual.

Please note that Ontario law does not permit hospitals to delete information from a patient's health record, even if that information is determined to be incorrect or incomplete. Instead, incorrect information is labelled as such and, in keeping with Ontario law, it continues to remain accessible within that record.

Please complete this form and submit it in person to the Members Health Records Department where you received care.

Part A: Patient Information

Legal First Name (print):	Middle Initial(s) (print):	Legal Last Name (print):

Date of Birth (yyyy/mm/dd):	Health Card Number:	Medical Record Number:

Street Address:

City:	Province:	Postal Code:

Telephone Number:	Email:

Substitute Decision Maker (SMD) Information (if applicable)

Legal First Name (print):	Legal Last Name (print):

Street Address:

City:	Province:	Postal Code:

Telephone Number:	Email:	Relationship to Patient

☐ Attached is a copy of documentation that provides authority as SDM.

Preferred Method of Communication

What is the best way to contact you?

☐ Telephone
May leave a detailed voice mail message? ☐ Yes ☐ No

☐ Email
☐ I acknowledge and understand that email messages are not encrypted, and therefore, the hospital cannot guarantee the security and confidentiality of messages I send or receive.

May we send a letter to the address provided on this form? ☐ Yes ☐ No

Details:

Part B – Correction Request Details

1. Is your health record incomplete? ☐ Yes ☐ No

   a. Title of Health Record Document which contains incomplete information (i.e. Discharge Summary, etc.):

   _____

   b. Date of Health Record Document which contains incomplete information: _____

   c. Name of Author/Care provider who signed/wrote the document (i.e. physician, nurse, physiotherapist, etc.):

   _____

   d. Specify the incomplete information in the document: _____

   _____

   e. Specify the complete information you wish us to record in your health record: _____

   _____

2. Is your health record inaccurate? ☐ Yes ☐ No

   a. Title of Health Record Document which contains inaccurate information (i.e. Discharge Summary, etc.):

   _____

   b. Date of Health Record Document which contains inaccurate information: _____

   c. Name of Author/Care provider who signed/wrote the document (i.e. physician, nurse, physiotherapist, etc.):

   _____

   d. Specify the incorrect information in the document: _____

   _____

   e. Specify the correct information you wish us to record in your health record: _____

   _____

The Member will respond as soon as possible in the circumstances but no later than 30 days after receiving your written request for a correction. Extensions of up to a maximum of 30 additional days are allowed, where replying within 30 days would unreasonably interfere with operations, or where the necessary consultations would not make it reasonably practical to reply within that time frame. In such situations, the Hospital will advise you in writing of the extension and set out the length of and reasons for the extension.

Patient/SDM (print):	Signature:	Date (yyyy/mm/dd):

Part C: Identification (For Health Records Department Use Only)

Identification validated date (yyyy/mm/dd):

Identification validated by:

◯ Clinician ◯ Health Records ◯ Other: _____

Identification provided:

◯ Driver's license ◯ Passport ◯ Citizen Card ◯ Other - please specify: _____

Validated by: Name and Role (print):	Signature:	Date (yyyy/mm/dd):

Part D: Response To Correction Request (For Internal Use Only)

Request for Correction to Health Record submitted to Author on Date: ____/_____/_____

Author: **Granted on Date:** ____/_____/_____

Refused* on Date: ____/_____/_____

*If you refuse to make a correction, the Member must inform the individual in writing of the refusal, the reasons for the refusal (please outline below), the individual's right to make a complaint to the IPC regarding the refusal and the right of the individual to require that the Hospital attach a Statement of Disagreement to the record that sets out the correction you have refused to make. The individual may require that the Member disclose the Statement of Disagreement when disclosing the information you refused to correct. The individual may also require that the Member make all reasonable efforts to disclose the Statement of Disagreement to any person to whom the Member has disclosed the information you refused to correct, except if the correction (if it had been granted) could not reasonably be expected to affect the ongoing provision of health care or other benefits to the individual.

***Author: Specify reason(s) for refusal** (this feedback will be shared with the requestor):

☐ I did not originally create this record of information and do not have enough knowledge, expertise and authority to correct.

☐ This information is a professional opinion or an observation that I made in good faith about the individual requesting the correction, (for example, if you are a physician and made a medical diagnosis in good faith).

☐ Other: _____

PART E: Additional Information (for Health Records Use only)

1. List names, contact information and comments of any individuals consulted.

2. If correction was not made, provide reasons:

3. If an extension to the correction request response was required, please indicate:
   a. Date of Extension: _____
   b. Reason for Extension: _____
   c. Date Patient Notified of Extension: _____
4. Notice of correction provided to others to whom incorrect information was disclosed. List names.

Proccesed by: Name and Role (print):	Signature:	Date (yyyy/mm/dd):