



**REQUEST FOR CORRECTION TO
CLIENT PERSONAL HEALTH INFORMATION**

Client Information			
Last Name:	First Name:	Int.	
No.:	Street Name:	Apt. No.:	
City:	Province:	Postal Code:	
Contact #:		Alternate #:	
DOB:	HCN:	E-mail:	
Parent/Guardian Information			
Last Name:	First Name:	Relationship to Client:	
No.	Street Name:	Suite No.:	
City:	Province:	Postal Code:	
Contact #	E-mail:	Lives with Client <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is the listed Parent/Guardian permitted to make decisions on behalf of the client?: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Correction to be Made to Personal Health Information			
<ul style="list-style-type: none"> Please attach a copy of the record you wish to have corrected; drawing a line through or highlighting the information that you wish to be corrected. List below the information you wish to be included on the client record. 			
Requested Correction:			
Reason(s) for Correction:			
Client/ SDM/ Parent One (Print Name)	Signature	Date	
Parent Two (Print Name)	Signature	Date	
Would you like us to give notice of the correction(s), 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.)			
<input type="checkbox"/> Yes <input type="checkbox"/> No			

(For Internal Use Only)

Client Name _____

Client Chart #: _____

Correction Request Response

Correction(s) made

Statement of Disagreement attached to record

Correction(s) not made

Other _____

Refusal letter (with reason) sent

Date of Response _____

List names, contact information and comments of any individuals consulted:

If correction was not made, provide reasons:

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

Date of Extension: _____

Reason for Extension: _____

Date Client Notified of Extension: _____

List name of those to whom a notice of correction has been sent:

Processed By:

Name _____ Title _____

Signature _____ Date _____

All information provided on this form will be used and disclosed in compliance with the Personal Health Information Protection Act.

Please Forward Requests to:

Privacy Office, Grandview Kids, Oshawa-Main Site
600 Townline Road .S. Oshawa, ON.

Phone: 437 529 0044 **Fax#:** (905) 728-2961 **Email:** roi@grandviewkids.ca