

**Correction Request Form**

- Please complete this form with as much information as possible.. This will help Sinai Health (SH) fulfill your request.
- SH only accepts requests from the patient or someone authorized to make a request for the patient (i.e. substitute decision maker). You will be required to provide proof of your identity.

*First Name:

*Last Name:

*OHIP or Medical Record #

☐ I have attached a copy of the patient's identification issued by a federal, provincial, municipal or state authority (i.e. driver's license, health card, passport)

Preferred Method of Contact ☐ Phone ☐ Email

Address:

City:

Postal Code:

Telephone Number:

Email Address:

Substitute Decision Maker Information (if applicable)

First & Last Name

Email Address

Address:

City:

Postal Code:

Telephone Number:

Preferred Method of Contact

☐ Phone ☐ Email

☐ I have attached documentation demonstrating that I am the patient's substitute decision maker (e.g. Court order for Guardianship, Power of Attorney for Personal Care)

Understanding & Authorization

- I understand that correction requests will only be made where:
 1. SH determines the record is incomplete/inaccurate for the purposes for which it is used;
 2. I have provided the information needed to make the correction; and
 3. The record that I am requesting a correction to was originally created by SH.
- I also understand that if SH concludes that the original record contains professional opinions or observations that were made in good faith, the request may be denied.
- In the case that the request is denied, SH will provide me with a written notice explaining the reason(s) and give me an opportunity to submit a statement of disagreement, which will be added to my medical record, and accompany any future disclosures of the record.

☐ I have attached additional details regarding this request on the following page

Signature of Patient/
Substitute Decision Maker:

Date: (dd/mm/yyyy)



Request Details

You may request a correction to your health records if you have been granted access to the records and you believe they contain inaccurate or incomplete information. Each patient request will be evaluated on a case-by-case basis.

Please be as specific as possible in your request. You may use the appendix attached to guide you if helpful. Please provide a copy of the record or report that you are requesting to be corrected and any supporting documentation necessary to substantiate the correction. Please keep the reason(s) for the correction brief.

*If you are using artificial intelligence (AI), there is a risk it may make your request unnecessarily complex or inaccurate. It is your responsibility to ensure your request is genuinely focused on what you are searching for. If not, it may slow down our response or result in a response not focused on your request.

Tips: please keep your request short and straightforward, avoid using legal references or terms, and check for tone to avoid abrupt or inappropriate language

If you have questions, please contact the SH Privacy & Information Access Office at 416-586-4800 ext.2101 or email privacyoffice@sinaihealth.ca with your name and phone number.

Correction Request Details Template

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