Correction Request Form

- Please complete this form with as much information as possible. Fields indicated with an asterisk (*) are mandatory fields. 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.
- Mail, email or fax the completed form to the SH Privacy Office:
  - Mail: 600 University Avenue, Room 1291
Toronto ON M5G 1X5
  - Email: privacyoffice@sinaihealth.ca
  - Fax: 416-586-5280

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.

Part I – Patient Information		
*First and Last Name:		*OHIP or Medical Record #:
*Date of Birth:	*Telephone #:	
*Address:		
*City:	*Province:	*Postal Code:
* ☐ I have attached a copy of the patient's identification issued by a federal, provincial, municipal or state authority (i.e. driver's licence, health card, passport)		I give permission for SH Privacy to leave a voicemail at the number above: ☐ Yes ☐ No
Part II – Substitute Decision Maker Information (if applicable)		
First and Last Name:		Telephone #:
Address:		
City:	Province:	Postal Code:
☐ 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)		I give permission for SH Privacy to leave a voicemail at the number above: ☐ Yes ☐ No

Part III – 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 provide a description of your request below. Be as specific as possible, including the personal health information that you are requesting be corrected (provide a copy of the record or report where possible), the reason(s) that the personal health information is incomplete or inaccurate and any supporting documentation necessary to substantiate the correction.

☐ I have attached additional details regarding this request.

Part IV – Understanding & Authorization

- I understand that correction requests will only be made where:
  a) SH determines the record is incomplete/inaccurate for the purposes for which it is used;
  b) I have provided the information needed to make the correction; and
  c) 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.

*Signature of Patient/Substitute Decision Maker:	*Date (dd/mm/yyyy):