MOUNT CARMEL CLINIC

REQUEST TO CORRECT PERSONAL HEALTH INFORMATION

PART 1 PATIENT / CLIENT INFORMATION

Last Name: _____ First Name: _____

Date of Birth DD/MM/YYYY:_____

Address: Street Name & Number / City / Province / Postal Code: _____

Phone Numbers: Home: ( ) _____Work: ( ) _____ Cell: ( ) _____

PART 2 I REQUEST THE FOLLOWING CORRECTION

Date(s) and where services provided: _____

Specific correction to personal health information being requested:_____

_____

_____

This request is for a correction to my own information ☐ Yes ☐ No If NO – complete Part 3

PART 3 PERSONS PERMITTED TO EXERCISE THE RIGHTS OF AN INDIVIDUAL

Last Name: _____ First Name: _____

Address: Street Name/Number/City/Province/Postal Code: _____

Phone Numbers: Home: ( ) _____ Work: ( ) _____ Cell: ( ) _____

Indicate Your Authority: _____

You may be required to provide documentation to prove you have the legal authority to exercise the rights of the individual.

PART 4 SIGN OFF

Signature of Person Making Request: _____Date: (dd/mm/yyyy) _____

You will be contacted within 30 days of the receipt of your request to advise of how it will be handled.

PART 5 OTHER

Signature of Privacy Officer: _____Date Received: _____(dd/mm/yyyy)