Southern Health Santé Sud

REQUEST TO CORRECT PERSONAL HEALTH INFORMATION

(ce formulaire est aussi disponible en français).

PART 1: PATIENT/CLIENT/RESIDENT INFORMATION

LAST NAME _____ FIRST NAME _____

Date of Birth: D D M M M Y Y Y Y Health Card Number: _____ (9 digit number)

Address: _____
STREET NAME AND 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 personal health information: ☐ Yes ☐ No **If NO – complete Part 3.**

PART 3: PERSON PERMITTED TO EXERCISE THE RIGHTS OF AN INDIVIDUAL

LAST NAME _____ FIRST NAME _____

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

Address: _____
STREET NAME AND NUMBER CITY PROVINCE POSTAL CODE

Indicate Your Authority: _____

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

Part 4: SIGN OFF BY PATIENT/CLIENT/RESIDENT OR PERSON PERMITTED TO EXERCISE THE RIGHTS OF AN INDIVIDUAL

Signature of Person making Request: _____ Date: D D M M M Y Y Y Y

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

Part 5: OTHER

Signature of Privacy Officer/Designate: _____ Client ID/Health Record #: _____

Date Received: _____

Guideline for Completing the "Request to Correct Personal Health Information (PHI) Form"

This form is to be used when an individual (a patient receiving health services from a hospital, client receiving community health services or a resident in a personal care home) requests a correction to their own PHI; or when a person permitted to exercise the rights of an individual requests a correction to PHI about the individual.

Part 1: Consent from Patient/Client/Resident.

- Record the last name, first name, date of birth, health card number (the 9 digit PHIN in Manitoba or another jurisdictions health card number), address (in full) and telephone numbers of the individual the information is about.

Part 2: I Request the Following Correction:

- Specify the date(s) and where health care services were provided; include the name of the hospital, personal care home, clinic, community health centre, and/or program such as midwifery, home care, public and mental health.
- Specify the correction to personal health information that is being requested. State what information the individual believes to be incorrect and where possible, state what the individual believes to be the correct information.
- Indicate if the request is for the patient's/client's/resident's own information, if so check "yes", if not check "no" and complete Part 3.

Part 3: Person Permitted to Exercise the Rights of an Individual

- Record the last name, first name, complete address and phone numbers of the person permitted to exercise the rights of an individual the information is about.
- Indicate the authority to request a correction to the PHI from the following list:

  (a) any person with written authorization from the individual to act on the individual's behalf;
  (b) a proxy appointed by the individual under The Health Care Directives Act;
  (c) a committee appointed for the individual under The Mental Health Act if the committee has the power to make health care decisions on the individual's behalf;
  (d) a substitute decision maker for personal care appointed for the individual under The Vulnerable Persons Living with a mental Disability Act if the exercise of the right relates to the powers and duties of the substitute decision maker;
  (e) the parent or guardian of an individual who is a minor, if the minor does not have the capacity to make health care decisions;
  (f) if the individual is deceased, his or her Personal Representative.

  If it is reasonable to believe that no person listed in any clause above exists or is available, the adult person listed first in the following clauses who is readily available and willing to act may exercise the rights of an individual who lacks the capacity to do so:

  (a) the individual's spouse, or common-law partner, with whom the individual is cohabitating
  (b) a son or daughter
  (c) a parent, if the individual is an adult;
  (d) a brother or sister;
  (e) a person with whom the individual is know to have a close personal relationship;
  (f) a grandparent;
  (g) a grandchild;
  (h) an aunt or uncle;
  (i) a nephew or niece.

  Ranking: The older or oldest of two or more relatives described in any clause of the above is to be preferred to another of those relatives.

Part 4: Sign Off

- Signature of the patient/client/resident or the person permitted to exercise the rights of an individual (as described in Part 3).
- Date of request.

Part 5: Other

- Signature of Privacy Officer/Designate.
- Record the date the request was received and the Client ID/Health Record #.
- File the completed Request to Correct of PHI form on the patient's/client's/resident's health record.

Reference: ORG.1411.PL.104 Correction of PHI