NORTH YORK GENERAL
Making a World of Difference

Release of Patient Information
North York General
4001 Leslie Street, 1W-Rm. 118
Toronto, ON, M2K 1E1
Tel: 416-756-6209
Fax: 416-756-6705
www.nygh.on.ca

REQUEST FOR CORRECTION TO PERSONAL HEALTH RECORD

STATEMENT OF DISAGREEMENT REQUEST

Under the *Public Hospitals Act*, hospitals and other care providers are not permitted to re-write reports or records of health care provided. We will attach a Statement of Disagreement to a health record if it is demonstrated, to our satisfaction, that the record is not correct or complete for the purpose for which we collect, use or disclose the information. We will make every effort to respond to your request in a timely fashion. Please complete and forward to NYGH's Release of Patient Information Department.

PATIENT CONTACT INFORMATION

Last Name	First Name	Initial
No.	Street Name	Apt. No.
City	Province/State	
Country	Postal Code/Zip	
Phone #	Alternate Phone #	
OHIP #	Date of Birth	

IF YOU ARE A SUBSTITUTE DECISION-MAKER, YOUR CONTACT INFORMATION

Last Name	First Name	Initial
No.	Street Name	Apt. No.
City	Province/State	
Country	Postal Code/Zip	
Phone #	Alternate Phone #	

Note: Please include copies of documents that provide your authority as a substitute decision-maker

(Form continues on next page)

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CORRECTION REQUEST

Please describe or attach the correction requested, with reasons for the correction.

How do you wish to receive notice of the correction? E.g. in writing, by telephone

Would you like us to give notice of the correction, 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 of otherwise benefit you).

☐ Yes ☐ No

Patient/Substitute Decision Maker (Print)	**Signature**	**Date**

If the person signing is not the patient, please provide NYGH with documentation of your authority to obtain this information.

Please Forward to:
Release of Patient Information, North York General, 4001 Leslie Street, 1W-Rm.118
Toronto, Ontario, M2K 1E1
Fax: (416) 756-6705
Phone: (416) 756 - 6209,

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RESPONSE (For Internal Use Only)

- ☐ Refusal letter (with reason) sent
- ☐ Statement of Disagreement attached to record
- ☐ Date of Response: _____

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

If Statement of Disagreement not attached, please provide reasons:

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

Date of Extension	Reason for Extension	Date Patient Notified of Extension

Notice of correction provided to others to whom incorrect information was disclosed (list names):

Processed by:	Name (Print)	Signature	Title