**Request to Correct Personal Health Information**
**Under the Personal Health Information Protection Act, 2004**

DATE (YYYY/MM/DD) ______________________________

**YOUR INFORMATION** (name on the clinical record):

SURNAME ______________ GIVEN NAME ______________ INITIALS ________

ADDRESS ______________________________ UNIT ____________

CITY ______________ PROVINCE __________ POSTAL CODE ____________

TELEPHONE ____________________

**SUBSTITUTE DECISION-MAKER INFORMATION***

SURNAME ______________ GIVEN NAME ______________ INITIALS ________

ADDRESS ______________________________ UNIT ____________

CITY ______________ PROVINCE __________ POSTAL CODE ____________

TELEPHONE ____________________ RELATIONSHIP ____________________

** Please note that you may be asked to provide documentation to satisfy that you are the substitute decision-maker.*

PLEASE PROVIDE A DETAILED DESCRIPTION OF THE PERSONAL HEALTH INFORMATION TO WHICH ACCESS HAS BEEN GRANTED AND THAT YOU ARE REQUESTING TO BE CORRECTED, THE REASONS THE PERSONAL HEALTH INFORMATION IS INCOMPLETE OR INACCURATE AND THE INFORMATION NECESSARY TO ENABLE THE CORRECTION OF THE PERSONAL HEALTH INFORMATION.

SIGNATURE ______________________________
(Substitute Decision Maker)

SIGNATURE ______________________________ DATE ____________________
(Child/Youth)

**Please send the completed form to Wellkin via email at info@wellkin.ca or by fax at 519-539-7058.**

**For questions, please call 1-877-539-0463 and ask to speak to a member of the Data and Administration Team.**

Form Updated: June 30, 2023