PATIENT’S REQUEST TO CORRECT PERSONAL INFORMATION

If you believe your patient records with our office are inaccurate or incomplete, you (or your legally authorized representative) may ask us to correct the error or omission. Our privacy officer, ________________________________, will explain the process.

Within 30 days of receiving your completed request, we will correct any information in your patient record that we have verified to be inaccurate or incomplete, then send a copy of the corrected record to each organization to which the inaccurate or incomplete information was disclosed within the past year.

If we decide that no correction is necessary, our privacy officer will explain the reasons for this. We will not correct or change an opinion, including a professional or expert opinion. We will note your requested correction and reasons for not making any correction and include it in your record, to indicate a correction was requested but not made.

If you disagree and believe that a change should have been made, we will attempt to resolve the matter with you. If we cannot resolve the matter, we will tell you how to request a review by the College of Physicians and Surgeons of BC. If you are still unsatisfied after that review, you may take the matter to the Office of the Information and Privacy Commissioner for BC.

The information on this form will be used to respond to your request to correct your personal information or the personal information of someone whom you are legally entitled to represent.

Patient’s Information

Mr / Mrs / Ms (please circle)		Street Address	
Last Name		City/Town	
First Name		Province	
Personal Health Number		Postal Code	
Date of Birth (mm/dd/yy)		Tel (bus / cell / home)	
Email Address		Fax	

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Please describe, in as much detail as you can, the information you want corrected. Be sure to give the complete patient name that is in the records if it is different from the name given above. If you need more space, please attach a separate sheet of paper.

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What correction or amendment do you want to make and why? Please attach any documents that support your request.

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Correction by Patient

______________________________ ______________________________

Patient Signature Date (mm/dd/yy)

Correction by Authorized Representative

I am a legally authorized representative of the patient named above and have attached proof of that representation. I hereby request access to the patient's personal records on his or her behalf.

Authorized Representative's Information

Mr / Mrs / Ms (please circle)		Street Address	
Last Name		City/Town	
First Name		Province	
Personal Health Number		Postal Code	
Date of Birth (mm/dd/yy)		Tel (bus / cell / home)	
Email Address		Fax	

______________________________ ______________________________

Authorized Representative's Signature Date (mm/dd/yy)