Consent for Correction of Personal Health Information

under the *Personal Health Information Protection Act, 2004*

Name of Health Information Custodian to Whom the Request is being made:

North Bay Parry Sound District Health Unit

Client Information (complete information for the person whose information is being requested):

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ They/Their

Surname: Given Name: Initials:

D.O.B.:

Address:

City: Province: Postal Code:

Telephone (Day and Evening):

Substitute Decision-Maker Information: (*Please provide documentation to satisfy the health information custodian that you are an authorized substitute decision-maker, if available.)*

Surname: Given Name: Initials:

Address:

City: Province: Postal Code:

Telephone (Day and Evening):

Please provide a detailed description of the personal health information you are requesting to be corrected (e.g. date of birth, dates of service or incident, name of health care provider, program area, etc.)

****Documentation must be provided to support the request, e.g., health card, proof of Power of Attorney (POA), custody document, or Substitute Decision Maker (SDM) for requests for someone other than yourself**

Signature:_____ Date:_____

For Health Information Custodian Use Only

Date Received:_____ Request Number:_____

The personal health information contained on this form is collected pursuant to the Personal Health Information Protection Act, 2004 ("the Act") and will be used for the purpose of responding to your request for access pursuant to section 54 of the Act. Questions about this collection should be directed to the Personal Health Information Lead at the health information custodian where the request for access is made.