Waypoint
CENTRE for MENTAL HEALTH CARE
CENTRE de SOINS de SANTÉ MENTALE

Request for Correction of Personal Health Record

Instructions: Please complete Parts A and B of this form and submit it to:

Waypoint Privacy Office
500 Church Street
Penetanguishene, ON L9M 1G3

Or privacy@waypointcentre.ca

Part A: Requester Information (all sections required)

Requestor name: _____ Requestor date of birth: _____ (d/m/y)

Patient name (if different than the requestor): _____

Patient date of birth: _____ (d/m/y) Relationship to patient (if applicable): _____

Address: _____

Phone number: _____ Email address: _____

Preferred method of communication: ☐ Phone ☐ Email

*Please note that only the patient or their substitute decision maker can request a correction to the patient's record.

Part B: Request Details (all sections required)

Please provide or attach a detailed description of the record(s) and a description of the requested correction(s). Please include any supporting documentation you may have.

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Personal health information will be corrected 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. Please attach any supporting documentation. You will be notified of the hospital's decision and available next steps within 30 days of submitting your request.

Part C: Request Information (For hospital use only)

Date received: _____ (d/m/y) Request #: _____

Comments: _____