Clear Form

Covenant Health
Compassionate care led by Catholic values

Request to Correct or Amend Health Information

Health Information Act

Please submit your completed form to the Health Records department of the health care facility where the records for consideration of correction or amendment are located. To locate health care facility information, please visit our website at https://www.covenanthealth.ca/locations.

Requestor Information		
○ Mr ○ Ms ○ Dr ○ Mrs ○ Miss	Last Name	First Name
Mailing Address		
City/Town	Province	Postal Code
Telephone *(Business)*	Telephone *(Home)*	Fax Number
Email Address		

Patient Information *(Provide information about the individual who is the subject of the correction or amendment request.)*		
☐ Same as above	Last Name	First Name
Date of Birth *(dd-mmm-yyyy)*	Personal Health Number/ULI	

Request Information

Type of Request

☐ **This is a request for correction or amendment of my health information.**

☐ **This is a request for correction or amendment of someone else's health information.**

Proof of your authority to act on behalf of another individual who is the subject of the health information or a valid written consent from the individual who is the subject of the health information **must** be attached.

Please clearly identify the health record(s) you want corrected or amended. *(If you have a copy of the record(s) you want corrected or amended, please attach them to your request.)*

What health information do you want corrected or amended? (*Be clear, concise, and specific when you identify the information within the health record(s).)*

What additional documentation do you have to support your request? *(When you identify the information in your health record(s) that you believe is wrong and/or where there is a mistake, please provide supporting documentation containing objective evidence that demonstrates where there is an error. A statement of personal opinion will not be considered as supporting documentation or objective evidence.)*

Signature	Date *(dd-mmm-yyyy)*

For authorized office use only	
Date received *(dd-mmm-yyyy)*	Request number/pMRN

Personal information on this form is collected under section 20 of the Health Information Act and will be used to respond to your request. If you have questions about COV's collection and use of your personal information, contact Information and Privacy at 1.866.254.8181 or email privacy@covenanthealth.ca.