Request to Correct Personal Health Information From the Clinical Record Compiled at EveryMind

Under the Personal Health Information Protection Act, 2004

Child/Youth Information

Last name: _____

First name: _____

Date of Birth: _____

Address: _____ Apt./Unit #: _____

City: _____ Province: _____ Postal Code: _____

Phone (home): _____ Phone (cell): _____

*Parent/Legal Guardian (substitute decision-maker) Information**

Last name: _____

First name: _____

Address: _____ Apt./Unit #: _____

City: _____ Province: _____ Postal Code: _____

Phone (home): _____ Phone (cell): _____

***** *You may be asked to provide documentation that demonstrates that you are the authorized substitute decision-maker*

Correction requested *(please describe information to be corrected, reasons information is inaccurate or incomplete and provide corrected information)*

_____

_____

_____

Child/Youth Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Please complete this form and fax to Clinical Records 905-696-0350 **OR**
mail to EveryMind Clinical Records, 85A Aventura Court, Mississauga ON L5T 2Y6
For more information call Clinical Records 905-795-3500 ext. 2323

For office use only:

File #: _____

Date request received: _____ Date manager notified: _____

Outcome of request, including resolution date: _____

_____