

### Correction Request Form

- Complete this form with as much information as possible.
- The Lake of the Woods District Hospital (LWDH) will only accept requests from the patient/client or someone authorized on behalf of the patient/client to make the request (i.e., substitute decision maker).
- LWDH reserves the right to verify the identity of the requestor prior to processing the request (i.e., photo identification, and appropriate documentation authorizing the request).
- Ontario legislation (PHIPA) allows a healthcare provider to charge administrative fees to a person who wants a copy of their medical record. The LWDH may ask that a fee is paid before giving a copy of a medical record.

<b>Patient/Client Information</b>		
Last Name:	First Name:	Middle Name:
Contact Information if it is different than the information we have on file):		
<b>Person Making the Request (<i>Only complete if you are not the patient/client</i>)</b>		
Last Name:	First Name:	Middle Name:
Relationship to the Patient/Client:		
Contact Information:		
<b>Nature of the Change(s):</b>		
Describe the information that you feel is not correct or out-of-date, and the suggested correction(s). Provide as much detail as possible.		
<b>Permission to Leave a Voicemail</b>		
If we need to confirm information or contact you, we will call the phone number that you provided above. May we leave a message if you do not answer the phone?		
<input type="checkbox"/> Yes, you may leave a message. <input type="checkbox"/> No, you may not leave a message.		
Provide any instructions about leaving a message (i.e., only on electronic voicemail, on with the person that answers the phone, etc.).		
<b>Signature</b>		
<b>Name:</b>	<b>Signature:</b>	<b>Date:</b>

<b>For Lake of the Woods District Hospital Use Only</b>		
Date Received:	Identity Confirmed: <input type="checkbox"/> Yes <input type="checkbox"/> No	Notes: