northern health
the northern way of caring

Request to Correct Personal Information

Last Name: _____ First Name: _____ Middle Name: _____

Personal Health Number (PHN): _____

ADDRESS INFORMATION:

Street, Apt. # PO Box, RR#: _____ City/Town: _____

Province/Country: _____ Postal Code: _____

TELEPHONE INFORMATION:

Daytime Phone: _____ Cell Phone: _____ Other Phone: _____

DETAILS OF PERSONAL INFORMATION TO BE CORRECTED

Please provide details as to why you think there are errors or omissions concerning your personal information and attach any supporting documentation. Please attach a letter if there is not enough room on this form. (Note that only factual demographic information can be changed in the original record. Requests to change medical information will only be appended to the document in question)

All information contained on this form is collected under the Freedom of Information and Protection of Privacy Act and will be used only for the purpose as outlined in Section 29.

Print Name: _____ **Relationship:** _____

Signature: _____ **Date:** _____

On completion of this form, please fax or mail it to the Health Information Management Department in the facility you are requesting the correction to your health record on. Please look for the fax number and mailing addresses under the "locations" tab and click on " more info" for more details on the Northern Health external website

Administrative Use Only	
Print Name:	☐ Approved ☐ Not approved
Signature:	Date:
Reason:	