

# Personal Health Information Correction Request Form



Under *The Personal Health Information Act* (PHIA), any individual may request a correction to any personal health information maintained by CancerCare Manitoba that the individual may examine and copy. In order to best assist you, please provide the following information in full:

SECTION 1: Individual the Information is About		
Given Name(s)		Surname
Personal Health Identification Number (PHIN)		Health Registration Number
Date of Birth (mmm/dd/yyyy)		Phone Number
Address	City/Town	Postal Code

SECTION 2: Details of Correction
<p>Please provide a detailed description of the personal health information that you are requesting be corrected, the reason that the personal health information is incomplete or inaccurate and the information necessary to enable the correction of the personal health information:</p> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>

SECTION 3: Individual Seeking the Correction
<input type="checkbox"/> I am the individual this information is about (go to SECTION 5: Authorization) <input type="checkbox"/> I am authorized to exercise the rights of the individual this information is about (go to SECTION 4: Correction Authority)

**SECTION 4: Correction Authority**

Please check the applicable box below and attach documentation verifying that you are authorized to act on the individual's behalf:

- I have written/verbal authorization from the individual
- I am the individual's proxy appointed under *The Health Care Directives Act*
- I am the individual's committee appointed under *The Mental Health Act* and have the power to make health care decisions for the individual
- I am the individual's substitute decision maker for personal care appointed under *The Vulnerable Persons Living with a Mental Disability Act*;
- You are the parent or guardian of a minor and the minor does not have the capacity to make health care decisions; or
- The individual is deceased and you are the executor or administrator of the individual's estate;
- No person above exists or is available; as per Section 60(2) of PHIA (see page 3), I wish to exercise the rights of the individual who lacks the capacity to do so because I am related to them in the following way: \_\_\_\_\_

Print Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of Authorized Individual

\_\_\_\_\_  
(mmm/dd/yyyy)

**SECTION 5: Authorization**

I undertake that I have the authority indicated in Section 3 above to request a correction to this information.

I understand that I may be required to provide documentation confirming my authority to request a correction if I am not the individual the information is about.

Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of Authorized Individual

\_\_\_\_\_  
(mmm/dd/yyyy)

The information you are asked to provide on this form is collected under the authority of PHIA and is necessary to help us process and respond to your request. Any information you provide will be protected in accordance with PHIA. If you have any questions about the collection, use or disclosure of this information, contact:

CancerCare Manitoba - Medicolegal Correspondent  
675 McDermot Ave., Winnipeg, Manitoba, R3E 0V9  
Phone: (204) 787-2266 Fax: (204) 786-0185

<b>OFFICE USE ONLY</b>	
Date received:	Received by:
Transferred to another branch/trustee? <input type="checkbox"/> No <input type="checkbox"/> Yes – date:	
<input type="checkbox"/> Information corrected <input type="checkbox"/> Information <u>NOT</u> corrected – Details:	
Date individual notified:	Notified by:
Completed Date:	

## *The Personal Health Information Act (PHIA)*

### **Section 60**

#### **Exercising rights of another person**

- [60\(1\)](#) The rights of an individual under this Act may be exercised
- (a) by any person with written authorization from the individual to act on the individual's behalf;
  - (b) by a proxy appointed by the individual under *The Health Care Directives Act*;
  - (c) by a committee appointed for the individual under *The Mental Health Act* if the committee has the power to make health care decisions on the individual's behalf;
  - (d) by a substitute decision maker for personal care appointed for the individual under *The Vulnerable Persons Living with a Mental Disability Act* if the exercise of the right relates to the powers and duties of the substitute decision maker;
  - (e) by the parent or guardian of an individual who is a minor, if the minor does not have the capacity to make health care decisions; or
  - (f) if the individual is deceased, by his or her personal representative.

#### **If person unavailable**

[60\(2\)](#) If the trustee reasonably believes that no person listed in subsection (1) exists or is available, the adult person listed first in the following clauses who is readily available and willing to act may exercise the rights of an individual who lacks the capacity to do so:

- (a) the individual's spouse, or common-law partner, with whom the individual is cohabiting;
- (b) a son or daughter;
- (c) a parent, if the individual is an adult;
- (d) a brother or sister;
- (e) a person with whom the individual is known to have a close personal relationship;
- (f) a grandparent;
- (g) a grandchild;
- (h) an aunt or uncle;
- (i) a nephew or niece.

#### **Ranking**

[60\(3\)](#) The older or oldest of two or more relatives described in any clause of subsection (2) is to be preferred to another of those relatives.