Request to Correct or Amend Health Information Alberta

MAYFAIR® DIAGNOSTICS

Mayfair collects, uses, and discloses your personal health information in accordance with the provisions set out in Alberta's Health Information Act (HIA), which includes the provision of health services, the billing for those services, other specific authorized purposes, and will be used to respond to your request for correction or amendment of your own health information. **Please submit your completed form by:**

Mail: Mayfair Diagnostics, Privacy Officer
132 – 6707 Elbow Dr. SE,
Calgary, AB T2V 0E3

Fax: 1.403.777.3008

In person: Drop off in person in a sealed envelope addressed to Mayfair Privacy Officer at any of our clinic locations.

For questions regarding Mayfair's privacy policy or how to complete this form, contact Mayfair's Privacy Officer at 403.385.0265 or email privacy@radiology.ca.

REQUESTOR INFORMATION

Last name: ____________________ First name: ____________________

Mailing address: ____

City or town: ____________________ Province: __________ Postal code: ______________

Telephone (main): _____ _____ _____ Telephone (alternate): _____ _____ _____ Fax: _____ _____ _____

Email address: ____________________

PATIENT INFORMATION

☐ Same as above

Last name: ____________________ First name: ____________________

Date of birth (day/month/year): _____ /_____ /________ Health Card #: ____________________

REQUEST INFORMATION

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

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

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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.)*

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Your signature:

____ Date (day/month/year): _____ /_____ /________

For authorized office use only: Date received (day/month/year) _____ /_____ /______ Request #: ______________