



Freedom of Information & Protection of Privacy Act (FIPPA) REQUEST FOR CORRECTION OF PERSONAL INFORMATION

Name (last,first,middle) _____
Ms Mrs. Miss Mr Other

Company / Organization (if applicable) _____

Mailing address _____

City or Town _____ Territory/province/country _____

Postal code _____

Telephone (day) _____ (alternate) _____ Fax _____

Correction requested - Please list dates, events, agencies involved, file numbers, and any other details which will help locate the information you want corrected. If you are requesting a correction of personal information on behalf of another person, you must attach a signed letter of authorization or other proof of authority to act on that person's behalf. If you need more space, please attach a separate sheet of paper.

Your signature X _____ Date signed _____

For NDMH Office Use Only Request no. _____ Date received _____ Privacy Officer _____
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Please send completed form to: **Nipigon District Memorial Hospital
Privacy Officer
Box 37
Nipigon, ON P0T 2J0**

Personal information contained on this form is collected under the Personal Health Information Protection Act (PHIPA) and Freedom of Information and Protection of Privacy Act (FIPPA) and will be used only for the purposes of responding to your request.