

REQUEST TO AMEND PERSONAL INFORMATION

The information gathered on this form will be used to respond to your request to amend your personal information or the personal information of someone you are legally entitled to represent.

Whose information do you want to amend?

- My own personal information.
 Another person's personal information.

Please complete the "Patient Information" and "Amendments by Authorized Representative" sections below, and attach proof that you can legally act on behalf of that individual.

Patient information

Mr / Mrs / Ms (please circle)

Street address:

Last name: _____ City /town: _____
Prov. _____

First name: _____ Postal code: _____
Fax: _____

Health card number: _____ Tel: (home) _____ (bus)

Date of birth (dd/mm/yy): _____ Email address:

Please describe, in as much detail as you can, the information you want amended. Be sure to give the complete patient name that is in the records if it is different from the name given above. If you need more space, please attach a separate sheet of paper.

What amendment do you want to make and why? Please attach any documents that support your request.

X _____

Patient Signature

Date (dd/mm/yy)