CAMBRIDGE MEMORIAL HOSPITAL
700 Coronation Blvd.,
Cambridge, ON N1R 3G2
519-621-2330

Statement of Disagreement - Amendment Request

A request was made by the following patient or their substitute decision maker (SDM) to correct their record and it was denied. (A physician / clinician may deny the correction request based on their opinion the documentation is accurate, complete and made in good faith). The patient or their SDM has completed this Statement of Disagreement to attach to their record.

Section A

Patient Information

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss D.O.B.: _____ Health Card Number: _____

Last Name: _____

First Name: _____

Address: _____

_____

Telephone: _____

Substitute Decision Maker

Last Name _____

First Name _____

Address _____

_____

Telephone: _____

Section B

Detailed description of requested record(s) or personal information to be corrected:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Witness Signature _____ Patient or SDM Signature _____

Date _____

For Institution Use Only

Date Request Received: _____

Comments _____

_____