Information and Privacy Commissioner,
Ontario, Canada

Commissaire à l'information et à la protection de la vie privée,
Ontario, Canada

# PHIPA DECISION 246

Complaint HA22-00040

A Hospital

June 11, 2024

**Summary:** The complainant submitted a request to a hospital to correct his personal health information contained in an intake form for an addiction treatment program. The hospital denied the correction request based on sections 55(9)(a) and (b) of the *Act*. The adjudicator decides not to conduct a review because the complainant has not established, under section 55(8), that the hospital has a duty to correct the record.

**Statutes Considered:** *Personal Health Information Protection Act, 2004*, S.O. 2004, c. 3, Sch A as amended, sections 57(3), 57(4), 55(8) and 55(9)(a) and (b).

## BACKGROUND:

[1] This decision addresses a complaint filed with the Information and Privacy Commissioner of Ontario (IPC) under the *Personal Health Information Protection Act, 2004* (*PHIPA* or the *Act*) by an individual after a hospital refused his request for correction of his personal health information.

[2] The complainant contacted a hospital (the hospital or custodian) for outpatient addiction treatment. During a screening call, a social worker collected information from the complainant and made handwritten notes on a two-page intake form called a Catalyst Report (the record). The social worker noted that the complainant reported that he had

used "crack/cocaine" and that he had been prescribed cannabis to treat PTSD.[1]

[3] The complainant learned of the record and its contents when the record was produced in an unrelated litigation. He then made a request to the hospital to correct his personal health information contained in the record. In his correction request, the complainant wrote that he had a history of cocaine use, but never in crack form. He also wrote that, at the time he contacted the hospital for treatment, he had not yet been diagnosed with PTSD, a diagnosis he says followed his contact with the hospital by several months. He asked the hospital to correct the references to crack and PTSD.

[4] The hospital denied the correction request, giving the following written explanation:

> The hospital is denying your request to correct personal health information because the author of the information for which the correction has been requested is no longer with the organization, and the hospital does not have sufficient knowledge, expertise and authority to correct the record. [[2]] The hospital assumes that the author recorded an accurate reason of why the service was requested.
>
> If you can provide information to show that the record is inaccurate for the purposes for which the hospital has collected, uses or has used the information, the request may be reconsidered.
>
> If you do not agree with the decision, you may complete a Statement of Disagreement which will be filed onto your medical record.

[5] The complainant submitted a statement of disagreement which the hospital attached to the record.

[6] The complainant then filed this complaint with the IPC requesting that his personal health information be corrected and asking, among other things, that reference to crack "be removed or corrected."[3] A mediator was appointed to explore the possibility of resolution with the parties.

[7] During mediation, the complainant confirmed that he wants the record corrected by removing references to "crack" and "PTSD."

[8] The hospital notified the social worker of the complainant's request and sought her comments. The social worker responded with the following explanation for refusing to change her notes in the record:

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[1] Post-Traumatic Stress Disorder.
[2] The exception in section 55(9)(a).
[3] Although the complainant refers only to removal of references to crack, the complainant maintained during mediation that he also sought removal of the reference to PTSD.

> After reviewing the documents and the request, I do not believe I have sufficient information to determine that the information collected and recorded on the intake form I completed on November 29, 2017 is inaccurate – or that the client did not in fact report "crack" or "PTSD" to me on this day, and therefore, at this time, must deny the request to change the portions of the record I recorded.

[9] The mediator shared her response with the complainant during mediation. The complainant was not satisfied with the response.

[10] Also during mediation, the complainant submitted a consent directive[4] to the hospital to restrict the hospital's use and disclosure of his entire hospital records.

[11] With no further mediation possible, the complaint was transferred to the adjudication stage of the complaint process, where an adjudicator may decide to conduct a review.

[12] Upon reading the materials in the file, I made a preliminary assessment that there were no reasonable grounds for a review. I notified the complainant of my preliminary assessment and gave the complainant an opportunity to provide written representations in response to my preliminary assessment if he disagreed.

[13] The complainant submitted representations in support of his position that the hospital should make the requested corrections. The complainant asked that no portion of his representations, including the documents he attached, be shared with the hospital. As a result, I have not summarized their contents here, except to say that the complainant points to notations in clinical notes and records that he submits support his correction request, and to decoded OHIP billing summaries that he says do not contain billing codes for mental health treatment he says would be associated with a diagnosis of PTSD before the date on which the record was created.

[14] After considering the complainant's representations and the materials before me, I find that there are no reasonable grounds to conduct a review, pursuant to sections 57(3) and 57(4) of *PHIPA*, because the complainant has not met the initial onus of establishing a right of correction under section 55(8).[5]

## DISCUSSION:

[15] There is no dispute that the hospital is a "health information custodian" under section 3(1) of *PHIPA* or that the record contains the complainant's personal health

[4] Commonly known as a "lock-box" and discussed in more detail below.
[5] Given this finding, it is not necessary for me to determine whether any of the exceptions in section 55(9)(a) or (b) apply.

information as that term is defined in section 4(1).

[16] The sole issue in this complaint is whether the hospital has a duty to correct the complainant's record of personal health information in accordance with the complainant's request.

[17] I have the authority under sections 57(3) and (4) to decide to conduct a review of a complaint. These sections state, in part, that:

> (3) If the Commissioner does not take an action described in clause (1)(b) or (c) or if the Commissioner takes an action described in one of those clauses but no settlement is effected within the time period specified, the Commissioner may review the subject- matter of a complaint made under this Act if satisfied that there are reasonable grounds to do so.
>
> (4) The Commissioner may decide not to review the subject-matter of the complaint for whatever reason the commissioner considers proper.

**Should the complaint proceed to a review under *PHIPA*?**

[18] Section 55(1) of *PHIPA* permits an individual to request that a custodian correct a record if the individual believes that the record is inaccurate or incomplete for the purposes for which the custodian has collected, uses or has used the information.

[19] Section 55(8) provides for a right of correction to records of an individual's own personal health information in some circumstances. It states that:

> The health information custodian shall grant a request for correction under subsection (1) if the individual demonstrates, to the satisfaction of the custodian, that the record is incomplete or inaccurate for the purposes for which the custodian uses the information and gives the custodian the information necessary to enable the custodian to correct the record.

[20] Section 55(9) sets out exceptions to the duty to correct records. It states that, despite section 55(8), a custodian is not required to correct a record of personal health information if it consists of a record that was not originally created by the custodian and the custodian does not have sufficient knowledge, experience or authority to correct the record,[6] or if the record consists of a professional opinion or observation that a custodian made in good faith about the individual.[7]

[21] Read together, these provisions set out the hospital's duty to correct records of personal health information that are inaccurate or incomplete for the purposes for which the hospital uses the information, provided that the complainant meets the two

[6] Section 55(9)(a).
[7] Section 55(9)(b).

requirements set out in section 55(8) (and if so, then subject to the exceptions set out in section 55(9)(a) and (b)).

[22] Sections 55(11) and 55(12) give an individual whose correction request has been refused the right to require the custodian to attach a statement of disagreement to the record setting out their disagreement with any information contained in the record.

[23] A statement of disagreement may contain the requested corrections.

[24] The *Act* also allows individuals to withhold or withdraw their consent to the collection, use or disclosure of their personal health information for a particular purpose and to provide express instructions to health information custodians not to use or disclose their personal health information without consent in certain circumstances.[8] These provisions have come to be known as "lock-box" provisions.[9]

[25] As noted above, the complainant submitted both a statement of disagreement that was attached to his chart, and a consent directive over his entire record of personal health information at the hospital.

## ***Analysis and Decision***

[26] For the reasons that follow, I find that the complainant has not established that the hospital is required to make the requested corrections.

[27] Section 55(8) requires the complainant, as the individual asking for a correction, to meet two conditions to establish that the hospital is required to make the requested corrections. As I have noted above, the complainant must:

i. demonstrate to the satisfaction of the custodian that the record is incomplete or inaccurate for the purposes for which the custodian uses the information, and

ii. give the custodian the information necessary to enable the custodian to correct the record.

[28] I find that the complainant has not met either condition.

[29] First, the complainant's submissions do not address the purposes for which the hospital uses or used the intake form, which, in this case, appears to be to collect information about the basis for seeking addiction treatment and a first step in screening for eligibility for the outpatient program.

[30] Previous IPC decisions have found that not all personal health information

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[8] See sections 19, 20(2), 37(1)(a), 38(1)(a), 50(1)(e) and 55.6 of *PHIPA*.
[9] See PHIPA Decision 148. Although not a defined term in *PHIPA*, "lock-box" is a term commonly used to describe the right of individuals to withhold or withdraw their consent to the collection, use or disclosure of their personal health information.

contained in records held by health information custodians needs to be accurate in every respect. If a request is made to correct bits of information that have no impact on the purposes for which the custodian uses the information, and the custodian is not relying on the information for a purpose relevant to the accuracy of the information, the custodian is not required to correct it.[10]

[31] Second, the result of the complainant's refusal to provide the hospital with information in support of his request is that the second requirement in section 55(8) is also not met.

[32] The IPC has found that a custodian is not required to grant the correction request if the individual seeking the correction does not provide the custodian with the information necessary to enable it to correct the record.[11]

[33] In his consent directive, the complainant asked the hospital to place a lock-box over all of his records.

[34] In his representations disagreeing with my preliminary assessment, the complainant expressly states that none of the documents he has provided to the IPC in support of the correction request, and which contain his personal health information, are to be shared with the hospital.[12]

[35] By instructing that all his records at the hospital be locked and by refusing to provide the hospital with the information that the complainant asserts supports his request, I find that the complainant has not given the hospital the information necessary for it to correct the record.

[36] The complainant acknowledges in his representations that section 55(8) requires him "to give [the hospital] the information to correct the record." He says, however, that he is reluctant to do so, claiming that the hospital "does not have sufficient safeguards in place to protect any personal health information given to it." The complainant states that the documents he provided to the IPC with his representations are sufficient to grant his request because they "contain the information necessary to correct [the hospital's] record," but reiterates that they are not to be made available to the hospital.

[37] Although the complainant maintains that the documents that he has provided to the IPC are sufficient to require the correction, it is not enough under section 55(8) for the complainant to take the position that the hospital should rely on the complainant's assertions alone, without providing the hospital with the information necessary to enable

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[10] PHIPA Decisions 36, 39 and 40.
[11] PHIPA Decisions 36 and 39.
[12] The complainant's representations state, in part, that "First and foremost, no consent is being given for the release oof or the sharing of my medical records to any one or any other entity or institution other than [the IPC] only for the review purposes of IPC complaint HA22-00040 and for no other purpose." This stipulation appears on each page of the complainant's representations.

it to correct the record.

[38] In these circumstances, I find that there are no reasonable grounds for a review because the complainant has not met the initial onus of establishing a right of correction under section 55(8).

[39] Finally, as a practical matter, I note that *PHIPA* does not provide for the removal of information as a remedy. Section 55(10) states that, upon granting a request for a correction, the health information custodian shall make the requested correction by recording the correct information in the record and striking out the incorrect information in a manner that does not obliterate the record. There is no right in the *Act* to have the incorrect information in a record removed, replaced, or amended in such a way that the incorrect information is completely obliterated. The information must remain legible. In other words, even if a review were to proceed and result in an order for correction, the order could only require the hospital to strike out the incorrect information in such a way that the original entries remain legible.

[40] Having found that the complainant has not met the initial onus under section 55(8), I have decided not to conduct a review on the basis that I find no reasonable grounds to do so.

[41] I issue this decision in satisfaction of the notice requirement in section 57(5).

## NO REVIEW:

For the foregoing reasons, no review of this matter will be conducted under Part VI of *PHIPA.*

Original Signed By: June 11, 2024

Jessica Kowalski
Adjudicator