Information and Privacy Commissioner,
Ontario, Canada

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

PHIPA DECISION 316

Complaint HA23-00024

Oak Valley Health – Markham Stouffville Hospital

December 12, 2025

Summary: A complainant seeks a review of a hospital's response to their request to make corrections to their personal health information contained in emergency room records. The hospital made some corrections and refused to make other corrections indicating that the information the complainant seeks to correct falls within the professional opinions or observations exception under section 55(9) of the *Personal Health Information Protection Act*. In respect of the refused corrections, the hospital stated that it has placed a statement of disagreement with the complainant's record.

In this decision, the adjudicator exercises her discretion under section 57 of the *Act* not to conduct a review of the complaint. The adjudicator is satisfied that the hospital has responded adequately to the complainant's complaint under section 57(4)(a) and there are no reasonable grounds to conduct a review under section 57(3).

Statute Considered: *Personal Health Information Protection Act, 2004,* SO 2004, c 3, Sched A, sections 57(3), 57(4)(a), 55(1), (8), (9) and (11).

BACKGROUND:

[1] This no review decision addresses a complaint filed with the Information and Privacy Commissioner of Ontario (the IPC) under the *Personal Health Information Protection Act* (the *Act*) regarding a hospital's response to a request to make corrections to records of personal health information.

[2] The complainant contacted the Markham Stouffville Hospital (the hospital) following an attendance at the emergency department. The complainant requested corrections to the records created by a crisis worker during that attendance. The complainant seeks corrections to a medical report to remove references to "schizophrenia" and to the complainant being "delusional/paranoid." The complainant provided further clarification about the two parts of their request: the first part for corrections in respect of their personal health information in an emergency record and the second part in respect of corresponding narrative patient notes.

[3] The hospital responded stating, in part:

> **Corrections Request #1:** Emergency record
>
> [The ER physician] has corrected your Emergency Record dated August 14, 2017 as follows:
>
> Voices concerns
>
> ? query suspended
>
> Preoccupation with concerns
>
> 4/5) ?delusional disorder
>
> Please find attached a copy of the addendum to your record.
>
> **Corrections Request #2:** Patient Narrative Notes
>
> Your request to correct your personal information documented in the Patient Narrative Notes was reviewed by [the named crisis worker] most responsible for your care.
>
> The author of the record declined to make the requested changes on the basis that the record dated August 14, 2017, information contained in the record consists of a professional opinion or observation that was made in good faith.

[4] The complainant had previously completed a statement of disagreement, including a brief written summary of the information they considered to be incorrect. In its response to the correction request, the hospital stated that it had placed the complainant's statement of disagreement on their health record.

[5] The complainant filed a complaint with the IPC and a mediator was appointed to explore resolution. During mediation, the hospital confirmed that it maintained is position and no further corrections would be made. The hospital also confirmed that it was relying

on section 55(9) of the *Act* to deny the correction request.[1]

[6] The complainant advised that he is pursuing the request to correct the patient narrative notes. In addition, the complainant stated that the hospital should only be sharing a corrected version of their medical record with third parties, specifically with police agencies. Although not a part of the complaint, the hospital confirmed that it had not released the records to any police agency.

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

[8] Upon reading the materials in the file, I made a preliminary assessment that the complaint did not warrant a review. I notified the complainant of my preliminary assessment, together with my reasons, and gave the complainant an opportunity to provide written representations in response, if he disagreed. I informed the complainant that I would consider his representations before reaching a final decision.

[9] For the reasons that follow, I exercise my discretion not to conduct a review under the *Act* because there are no reasonable grounds to conduct a review (section 57(3)) and the hospital has responded adequately to the complaint (section 57(4)(a)).

DISCUSSION:

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

[10] Sections 57(3) and 57(4)(a) of the *Act* set out the IPC's authority to review or not to review a complaint. These sections state:

> (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 complainant for whatever reason the Commissioner considers proper, including if satisfied that,
>
> > (a) the person about which the complaint is made has responded adequately to the complaint;

[1] Section 55(9) provides exceptions to a custodian's duty to correct a record of personal health information. The hospital had not previously cited the specific section of the *Act* in its decision letter to the complainant.

[11] The Ontario Court of Appeal has confirmed that the *Act* provides the IPC a very wide discretion to decide whether or not to review a complaint.[2] In exercising this discretion, the IPC will consider the legislative framework of the *Act*, the correction request and the circumstances of the complaint, the complainant's submissions and the information relied upon to establish a right to correction under section 55(8) and the health information custodian's response to the correction request.[3]

[12] I have adopted this approach and, for the reasons set out below, have decided to exercise my discretion not to conduct a review under section 57(3) and (4)(a) of the *Act*.

The relevant legislation

[13] Section 55(1) of the *Act* permits an individual to request that a custodian correct a record of personal health information 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.

[14] Section 55(8) of the *Act* provides a right of correction to records of personal health information in some circumstances. Section 55(8) states:

> 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.

[15] Section 55(9) of the *Act* sets out exceptions to the obligation to correct records. The hospital claims the exception in section 55(9)(b), which states:

> Despite subsection (8), a health information custodian is not required to correct a record of health information if,
>
> (a) it consists of a record that was not originally created by the custodian and the custodian does not have sufficient knowledge, expertise and authority to correct the record; or
>
> (b) it consists of a professional opinion or observation that a custodian has made in good faith about the individual.

Right to correction under section 55(8)

[16] As the individual requesting the correction, section 55(8) of the *Act* requires the complainant to demonstrate that the records he wants corrected are "incomplete or

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[2] *Hopkins v. Kay* 2015 ONCA 112, at para 55.
[3] For example, see PHIPA Decisions 125, 291 and 308.

inaccurate for the purposes for which the custodian uses the information."

[17] The complainant states that the hospital (the custodian in this case) has made false mental health reports about him and that he was coerced by the police to undergo a mental health assessment. The complainant provided me with representations about his background, his education and his employment history leading to a human rights complaint against his former employer. In addition, the complainant provided me with information in occurrence reports from the York Regional Police.

Right to correct Emergency Record

[18] In the request, the complainant seeks to make corrections to an Emergency Record. The complainant states that the references to "paranoia" and "delusion" are incorrect and that the reference to his status as an MBA student was incorrectly recorded as "suspended."

[19] As noted above, the ER physician agreed to make four corrections to the Emergency Record. I have reviewed these corrections and note that the first references to paranoia have been struck through and the words "voices concerns" and "preoccupation with concerns" have been added; the reference to the complainant's student status as suspended has also been struck through and the words "?query suspended" have been added and the final diagnosis of delusional/paranoid has been struck through and the words "?delusional disorder" have been added.

[20] The complainant remains dissatisfied and has repeated his request that these records be corrected. However, the complainant has not addressed how the personal health information, as it has been corrected, remains inaccurate or incomplete, as required by section 55(8).

Right to correct Patient Narrative Notes

[21] There is no question that the accuracy of records containing personal health information is essential to the effective provision of health care. However, the correction provisions of the *Act* are limited by the requirement that the individual requesting the correction demonstrates that the record is incomplete or inaccurate *for the purposes for which the custodian uses the information*.[4] The accuracy of the information is therefore connected to the purposes for which it is used by the custodian.

[22] Previous IPC decisions have held that the obligation set out in section 55(8) does not mean that all personal health information contained in records held by a health information custodian needs to be accurate in every respect. If a request is made to correct inconsequential 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

[4] PHIPA Decision 36.

for a purpose relevant to its accuracy, the custodian is not required to correct it.[5]

[23] In the complainant's response to my preliminary assessment of his complaint, the complainant states that following the corrections made to the Emergency Record, the hospital "has a similar duty to similarly correct the patient narrative notes." The complainant states that he has submitted numerous pieces of evidence to the hospital to support the correction of the Patient Narrative Notes.

[24] From my review of the corrections being sought in the Patient Narrative Notes and the documentation provided in support, I find that the corrections concern facts and statements the complainant has made regarding information that has no impact on the purposes for which the hospital uses the information. I acknowledge that this information may be important to the complainant, however I am not persuaded that it is of consequence in the hospital's provision of health care. For example, the complainant seeks corrections to information about his level of education and the program he was enrolled in at the time the records were created. The record states that he "reported [his] highest education level as being in the 3rd year of [his] MBA" and the complainant is seeking to correct this to his highest level of education "completed" being a Bachelor of Science in Chemistry and a Post Graduate Diploma in Plastics Engineering Technology.

[25] Similarly, the complainant seeks to correct information about the circumstances of the termination of his MBA studies, information that he says demonstrates the threats and discrimination he has received while a student and references to his complaints about being under surveillance and related dates of terrorist incidents.

[26] I have carefully considered the complainant's representations and the documentation provided. In my view, the complainant has not demonstrated that the information in the Patient Narrative Notes is incomplete or inaccurate *for the purposes for which the custodian uses the information*.

[27] For these reasons, I find that the complainant has not demonstrated his right to have the Emergency Record or the Patient Narrative Notes corrected under section 55(8) of the *Act*.

Exception for professional opinions or observations made in good faith in section 55(9)(b)

[28] To the extent that the complainant seeks corrections to references in his records to paranoia and delusional disorder, even if I find that he has discharged the burden of section 55(8), in the circumstances of this complaint, I find that the "professional opinions or observations" exception in section 55(9)(b) applies.

[29] The complainant seeks corrections of the references to paranoia and delusional disorder in the Emergency Record only. The exception in section 55(9)(b) preserves

[5] See PHIPA Decision 36.

"professional opinions or observations," accurate or otherwise, that have been made in good faith. Again, the burden rests with the complainant as the individual seeking the correction, to demonstrate that the author of the Emergency Record did not make their professional opinions or observations in good faith.

[30] In his response to my preliminary assessment of the complaint, the complainant gives a time line of events setting out the contextual background to the correction request that focuses on harassment and threats that he believes are linked to the custodian's refusal to make the corrections he is seeking. The complainant maintains that the mental health assessment in the Emergency Record has been made in bad faith to support third party activities.

[31] I have considered the evidence that the complainant has provided in support of his position, however, I am not persuaded that there is a reasonable basis for me to find that the opinions regarding paranoia and delusional disorder in the Emergency Record were not made in good faith.

[32] I remain of the view that the fact that the ER physician has made corrections in the Emergency Record is evidence of good faith. For these reasons, there is no reasonable basis for me to find that the professional opinions or observations in the records were not made in good faith so that even if the complainant discharges the burden in section 55(8), I find that the exception in section 55(9)(b) would apply.

Custodian's refusal to correct and section 55(11)

[33] Section 55(11) of the *Act* provides that a custodian must provide notice of its refusal to an individual requesting a correction to records of their personal health information. As I explained in my preliminary assessment, this notice must inform the complainant that he is entitled to prepare a statement of disagreement setting out the corrections that have been refused. In addition, the complainant may require the custodian to attach the statement of disagreement as part of the records to which it relates.

[34] As the hospital has refused the complainant's request for corrections to the Patient Narrative Notes, I have therefore considered whether it has met its obligations under section 55(11).

[35] I have reviewed the hospital's response set out in its letter of February 2, 2023. In its letter, the hospital states that the complainant has completed a statement of disagreement that includes a brief, written summary of the information he believes is incorrect. The hospital also advises that the statement of disagreement was forwarded to anyone who was provided with a copy of the records the complainant is seeking to have corrected and will similarly be included in the future.

[36] In his representations, the complainant does not address the custodian's response. Accordingly, I remain satisfied that the hospital's response met its obligations under

section 55(11) of the *Act*, which is demonstrated by the statement of disagreement it has provided to the complainant and that now forms part of the records.

[37] For these reasons, I find that the hospital has responded adequately to the complainant in accordance with section 57(4)(a) and there are no reasonable grounds for me to conduct a review under section 57(3) of the *Act*.

NO REVIEW:

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

Original Signed by: December 12, 2025

Katherine Ball
Adjudicator