Information and Privacy Commissioner,
Ontario, Canada

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

PHIPA DECISION 317

Complaint HA24-00050

LasikMD

December 15, 2025

Summary: The complainant asked the custodian to correct records containing his personal health information related to an eye procedure. He complained to the IPC about the custodian's refusal to make certain corrections to the records.

The adjudicator determines that no review is warranted under sections 57(3) and 57(4)(a) of the *Act* because there are no reasonable grounds to review the complaint and the custodian has responded adequately to the complaint. The complaint is dismissed.

Statutes Considered: *Personal Health Information Protection Act, 2004,* S.O. 2004, c 3, Sched A, sections 3(1), 4(1), 55(1), (8), (11), 57(3) and (4).

Related Decision: PHIPA Decision 318.

BACKGROUND:

[1] This decision addresses a complainant's request to correct records of his personal health information (PHI) under the *Personal Health Information Protection Act* (the *Act* or *PHIPA*) to LasikMD (the custodian). The records relate to an eye procedure performed on the complainant. The complainant says the procedure resulted in an over-correction which negatively impacted his eyesight. He says that the information he has requested to be corrected in the records would better reflect what occurred and would ensure that future caregivers have accurate information.

[2] After submitting a request to the custodian for records related to the eye procedure, the complainant received medical records.[1] The complainant subsequently filed a correction request to the custodian seeking corrections to these records.

[3] The custodian issued a decision, in which it granted two of the four corrections requested by the complainant.

[4] The first correction request asked the custodian to correct the date of scans described in his medical record.[2] The custodian's correction decision says that the system inserted the incorrect date and that the record would be corrected to the correct date the scans were performed.

[5] The second correction request asked the custodian to correct a number reported in his medical record.[3] The custodian's correction decision said that there was a mistake in the calculation and the custodian agreed to correct the record but not in the exact manner requested by the complainant.

[6] The third correction request sought the deletion of a reference in the record of a medical device being used during the procedure.[4] The custodian's correction decision denied this request taking the position that the information the complainant seeks to correct constitutes the doctor's professional opinion or observations.

[7] The fourth correction request says that the doctor's notes of a discussion he had with the complainant does not accurately reflect what the doctor said.[5] The complainant also seeks to modify the reference in the medical record describing his medical condition as "mild." The custodian's correction decision denied this request taking the position that the information the complainant seeks to correct is based on the doctor's professional

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[1] There is no dispute that the records contain the "personal health information" of the complainant, within the meaning of paragraphs (a) and (b) of section 4(1) of the *Act*. In addition, there is no dispute that the custodian is a "health information custodian" within the meaning of section 3(1) of the *Act*.

[2] The complainant says in his correction request that the "WaveLight Diagnostic Data [presumably Oct 11, provided to me on Nov 2nd: the date of these scans is listed as April 25th when no scans were done on this date]. Also, it seems like the scans were input in reverse order so it seems like the times are incorrect as well."

[3] The complainant says in his correction request that the "WaveLight EX500 Treatment report (Oct 11 PTK) (provided to me on Nov 2nd) The residual stroma number is 441um. This doesn't match with the understanding that the PTK was performed as the initial action to remove epithelium. I believe this number should read 481um to be consistent with the other treatment report, if this PTK was the initial ablation. If the 441um number is correct, I believe there must be a missing record of another PTK performed to 40um."

[4] The complainant says in his correction request that the "Oct 11 surgeon's notes (provided to me on Oct 27th - second package of the day) 'Amolis Brush 24u' I don't recall a brush being used during the procedure."

[5] The complainant says in his correction request that the "Nov 16 discussion notes (provided to me on Nov 22nd) long discussion regarding exact surgical technique (including discussion of PTK effect (mild myopic induction) on PRK nomogram This does not match with my records of the discussion. You verbally indicated to me that the PTK was the main driver for the over correction applied to my eye and gave me numbers to substantiate that my PTK induced more than a 0.44 diopter change. I believe calling this effect mild in the written record is materially misleading and obfuscates the surgical parameter justification explained to me."

opinion or observations.

[8] In response, the complainant filed a complaint with the Information and Privacy Commissioner of Ontario (IPC) and a mediator was assigned to explore settlement with the parties.

[9] During mediation, the custodian confirmed that it relies on section 55(9)(b) of the *Act* to support its decision to deny the complainant's correction request. The complainant told the mediator that he had an audio recording which he says supports his request for correction. The complainant subsequently shared with the mediator, a copy of the recording along with a written explanation.

[10] The custodian confirmed with the mediator that it considered the complainant's additional evidence but it continues to take the position that it is not required to grant the complainant's third and fourth correction request.

[11] Also during mediation, the complainant asked for the reversal of the correction the custodian agreed to make in response to his second correction request. The complainant told the mediator that he now disagrees with the number reported in the record and that the original number should be inputted. The complainant explained that he believes that the corrected record does not accurately reflect what occurred during the procedure. In response, the custodian refused to make the reversal taking the position that reverting to the original number would not be accurate.

[12] Finally, the complainant after reading the corrected record, requested that the custodian "clean up" the records:

1. The complainant says that the corrections were not made consistently and as a result he says that the original record is preserved and at other times it is not. The complainant provided the following examples:

    - Pages 32-41 and 42-51 are duplicates with the only difference being the latter has been corrected with red strikethroughs, and

    - Pages 70-71 were corrected with a red strikethrough, yet the original was not maintained.

2. The complainant says that the information in his medical records should be re-organized so that there is a "logical flow". The complainant requested that:

    - The Nov 30 record (corrected to Oct 11) should be placed alongside the Oct 11 record, and

    - Statements of disagreement should be placed alongside the record it pertains to.

3. The complainant says that records should be placed in chronological order and that the following changes would "clean up" his records:

    - Pages 32-41 be removed
    - Pages 70-72 be bundled with 8-10
    - Pages 44-49 should be reversed to be in chronological order
    - Page 84 be bundled with 8-10
    - Page 85 be bundled with 60-61
    - Pages 86-87 be bundled with 50
    - Pages 88-89 be bundled with 8-10
    - Pages 90-91 be bundled with 8-10
    - Pages 92-93 be bundled with 56-57
    - Pages 94-95 be bundled with 58-59

4. The complainant says that the Wavelight Topography scans (pages 44–49) should be arranged in chronological order.

[13] The mediator shared the above with the custodian who agreed to only make the following additional changes to the records:

- Remove pages 32-41, leaving only the corrected version,
- Place the November 30 record (corrected to October 11) alongside the October 11 record, and
- Position the statements of disagreement next to the relevant records.

[14] The custodian provided the complainant with another copy of the records with the above-noted changes.

[15] At the end of mediation, the complainant said that he wants a review of the custodian's denial of corrections three and four along with its refusal to reverse correction two.

[16] The mediator's report also identified other issues the complainant raised during mediation. The complainant takes the position that the circumstances of this complaint reveal potential violations under the *Act*, delays, and inconsistent practices for correcting medical records that may affect his ongoing visual issues and future treatment decisions.

[17] Mediation did not resolve the complaint and the file was transferred to the adjudication stage of the complaint process in which an adjudicator may decide to conduct a review.

[18] After reading the complaint file, I wrote to the complainant advising him of my preliminary assessment that his complaint should not proceed to the review stage. The complainant was invited to provide written representations in response to my preliminary assessment before I made my final decision. The complainant submitted written representations in response.

[19] In this decision, I find that the complaint should not proceed to a review under the *Act* because there are no reasonable grounds to conduct a review (section 57(3)) and the custodian has responded adequately to the complaint (section 57(4)(a)).

DISCUSSION:

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

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

[21] After reading the complainant's written representations along with the contents of the complaint file which included the audio recording and written statement the appellant shared during mediation, I exercise my discretion not to review the subject-matter of this complaint finding that there are no reasonable grounds to conduct a review. I am also satisfied that the custodian has responded adequately to the complaint. I explain my reasons below.[6]

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[6] Throughout his representations, the appellant made arguments and presented evidence in support of his position that the eye procedure performed on him resulted in an over-correction which negatively impacted his eyesight. The appellant's evidence in this regard is not discussed in this decision as the IPC does not have the jurisdiction to assess the quality of health care individuals receive from their health practitioners.

There is no useful purpose served by a review of the complaint about the custodian's refusal to correct

[22] Section 55(1) of the *Act* sets out the right of an individual to request a correction to records of the individual's personal health information. This section states:

> If a health information custodian has granted an individual access to a record of his or her personal health information and 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, the individual may request in writing that the custodian correct the record.

[23] Section 55(8) sets out a duty on the part of a health information custodian to grant a request for correction where certain conditions are met. This section states:

> The health information custodian shall grant a request for a 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.

[24] If the requirements of section 55(8) are established, the question becomes whether or not any of the exceptions that are set out in section 55(9) apply. In the circumstances of this complaint, the custodian claims that the exception at section 55(9)(b) applies. This section states:

> Despite subsection (8), a health information custodian is not required to correct a record of personal health information if, it consists of a professional opinion or observation that a custodian has made in good faith about the individual.

The complainant has not discharged the onus in section 55(8)

[25] In all cases where a complaint regarding a custodian's refusal to correct records of PHI is filed with the IPC, the individual seeking the correction has the onus of establishing that the "record is incomplete or inaccurate for the purposes for which the custodian uses the information" pursuant to section 55(8).

[26] Section 55(8) requires the individual asking for correction to:

a. 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

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

[27] If the above is established, the question becomes whether or not any of the exceptions that are set out in section 55(9) apply. Accordingly, before I consider the custodian's claim that portions of the records contain professional observations or opinions, I must first determine whether the complainant has discharged the onus in section 55(8).

[28] Previous IPC decisions have found that not all PHI contained in records held by health information custodians 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 for a purpose relevant to the accuracy of the information, the custodian is not required to correct the information.[7]

[29] In addition, the IPC has found that the 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.[8]

[30] As noted above, the complainant seeks the following corrections:

- Deletion of a reference in the records of a medical device being used during the procedure (third correction request),
- Modify the reference in the medical records describing his medical condition as "mild" (fourth correction request), and
- Reverse the correction the custodian agreed to make regarding a number reported in the records (second correction request).

[31] In addition, the complainant requests that the custodian "clean-up" the records by making various changes to the presentation of information contained in the records.

[32] The complainant says that the records are "incomplete and inaccurate for the purposes for which the custodian uses the information – namely, clinical documentation, continuity of care, and legal accountability." In support of his position, the complainant states:

> The record incorrectly states that an Amoils brush was used during the procedure. This misrepresents a key component of the surgical technique. Prior to correction, the residual stomal thickness (RSB) value suggested that no epithelium remained, making the use of an Amoils brush unnecessary and clinically implausible. This inconsistency is particularly concerning that intraoperative pachymetry – a standard method for measuring corneal

[7] PHIPA Decisions 36, 39 and 40.
[8] PHIPA Decisions 36 and 39.

> thickness, built into the equipment used – was marked "N/A," and no such validation data was available in the record.
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> The custodian's willingness to amend the RSB value confirms that it was material to the record. Therefore, it would be inconsistent to argue that related information – such as the epithelial removal meth – is irrelevant or does not warrant correction.
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> These are not minor or isolated discrepancies. The method of epithelial removal directly impacts the interpretation of the surgery as demonstrated in [the attached letter[9]], postoperative outcomes, and future clinical assessments. If left uncorrected, the record may mislead future providers or undermine retrospective evaluations of patient outcomes. Furthermore, accurate documentation is essential for auditing surgical quality, refining nomograms, and supporting continuous quality improvement.

[33] Having read and considered the entire complaint file, including the written representations[10] the complainant submitted in response to my preliminary decision along with the materials he provided the mediator, I find that the complainant's evidence fails to establish a reasonable basis that the information at issue contained in the records is "incomplete or inaccurate for the purposes for which the custodian uses the information" as required by section 55(8) of the *Act*.

[34] I maintain my view, expressed in the preliminary assessment, that corrections sought by the custodian are not relevant for the purpose for which the custodian uses the information. The wording in section 55(8) is clear. The individual seeking the correction has the onus of establishing whether the "record is incomplete or inaccurate for the purposes for which the custodian uses the information".

[35] It is the custodian's use of the information that is relevant not whether the information is read, accessed or even understood by others. The accuracy of the information that is requested to be corrected is connected to the purposes for which the information is *used by the custodian*.[11] Here, the custodian's use of the records is to document the health care and services it provided to the complainant related to the eye procedure.

[36] In the circumstances of this complaint, it appears that the complainant plans to use the records to substantiate a legal claim and seek future health services. The complainant's evidence describes his use of the records not the custodian's. The

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[9] The attachment the complainant refers to in his representations is a medical opinion he obtained from an Ophthalmologist. I note that that this individual refers to himself, in the letter provided by the complainant, as a medical expert witness in Ophthalmology.

[10] The complainant also included appendices with his representations, one being a medical opinion he obtained from a licenced physician certified by the American Board of Ophthalmology.

[11] PHIPA Decision 36.

complainant's use of the records to advance a legal claim or seek future health services is a wholly appropriate use of the records for his purposes. However, the health provider's use of a record need not mirror the patient's use. In fact, the *Act* contemplates different uses and requires health providers to add a statement of disagreement to any record in its custody which contains the PHI of another individual.

[37] As stated above, the complainant has already prepared statements of disagreement, which the custodian has attached to the records.

[38] Having regard to the purpose of the records along with the complainant's evidence, I find no reasonable basis to support a finding that the complainant has discharged the onus in section 55(8). Accordingly, I find the custodian does not have a duty to correct the information under section 55(8).

[39] Given my finding, it is not necessary that I also determine whether the complainant gave the custodian the information necessary to enable it to correct the records. It is also not necessary that I determine whether the professional opinion or observation made in good faith exception at section 55(9)(b) applies.

The time frame in which the custodian attached his statements of disagreement to the records does not contravene section 55(11)(b)

[40] The mediator's report details the complainant's frustrations with the custodian's failure to attach his statements of disagreement with the record in a timely manner.[12]

[41] The mediator had discussions with the custodian which resulted in the custodian locating two statements of disagreement that the complainant had previously sent. The custodian subsequently confirmed that the statements of disagreement were added to the record. The complainant says in his representations that the custodian's delays in attaching his statements of disagreement demonstrates a "pattern of inaction" in contravention of 55(11)(b) of the *Act*. This section states:

> A notice of refusal under subsection (3) or (4) must give the reasons for the refusal and inform the individual that the individual is entitled to require that the health information custodian attach the statement of disagreement as part of the records that it holds of the individual's personal health information and disclose the statement of disagreement whenever the custodian discloses information to which the statement relates

[42] The complainant says that the delay he experienced in getting his statements of disagreement attached to the records resulted in key evidence not being available when

[12] The complainant also presented evidence in his representations in support of his position that he made at least four formal email requests inquiring about the status of his statements of disagreement. The complainant says that the first time he received a copy of the records attaching the statements of disagreement it was 290 days from when he filed the statements.

the records were sent to the College of Physicians and Surgeons of Ontario (CPSO). The complainant also says:

> Such a lengthy delay undermines accountability and infringes on my right to have health records accurately reflect my perspective when corrections are denied.
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> Further, this prolonged inaction shows more than administrative oversight; it reflects a pattern of neglect in handing correction requests and a disregard for obligations under *PHIPA*. The fact that corrected records were circulated without the attached statements, even after multiple written reminders, raises concerns about whether the custodian took its statutory duties seriously.

[43] Section 55(11)(b) requires the custodian to do three things when it issues a decision denying a requester's correction. One, give reasons for its refusal to correct the record. Two, inform the complainant that he is entitled to require that it attach a statement of disagreement to the record. Three, disclose the statement(s) of disagreement whenever the custodian discloses information to which the statement relates.

[44] I accept the complainant's evidence that there was a delay in his statements of disagreement being attached to the records. However, the delay he says he experienced does not evidence a contravention of section 55(11)(b). The complainant does not allege that the custodian failed to give reasons for its refusal, nor does he allege that it failed to tell him that he is entitled to require that a statement of disagreement be attached to the records. Finally, the complainant does not allege that the custodian did not attach the statements of disagreement to records it disclosed to a third party. In fact, there is no evidence before me that suggests that the custodian disclosed the records to any third party.

[45] Instead, the evidence before me is that the custodian attached the complainant's statements of disagreement to the records after the complainant alerted the custodian of the issue. In addition, the mediator facilitated a resolution of the issue which resulted in the custodian attaching additional statements of disagreement including the subsequent positioning of them to the relevant records as requested by the complainant.

[46] In my view, the complainant's concerns about delay raise customer service issues which I do not have the authority to comment on. I find that there is insufficient evidence before me to conclude that the custodian failed or refused to do any of the things contemplated in section 55(11)(b). Accordingly, I find that the circumstances of this complaint do not evidence a contravention of section 55(11)(b).

The custodian's failure to send the records to the CPSO does not contravene section 55(10)(c) of the *Act*

[47] This issue differs from the one above as the complainant alleges here that the custodian failed to provide the CPSO with a copy of the corrected records. The complainant alleges that the custodian's failure to provide the CPSO with a copy of the records with the corrections it granted is in contravention with section 55(10)(c). This section states:

> Upon granting a request for a correction under subsection (1), the health information custodian shall at the request of the individual, give written notice of the requested correction, to the extent reasonably possible, to the persons to whom the custodian has disclosed the information with respect to which the individual requested the correction of the record, except if the correction cannot reasonably be expected to have an effect on the ongoing provision of health care or other benefits to the individual.

[48] The complainant raised this issue during mediation and the custodian confirmed that it did not provide the CPSO with a copy of the records taking the position that it was refrained form sharing the records of the complainant's PHI to any third party not in the complainant's circle of care.[13] As a result of mediation, the custodian agreed to contact the CPSO and make arrangements to provide it with a copy of the records. However, the CPSO informed the custodian that its file with the complainant was closed and that it did not require any new information.

[49] The complainant confirmed that he wanted to pursue this issue in his representations, in which he states:

> By failing to disclose corrected records during an active regulatory review, despite my multiple explicit requests … the custodian undermined that process and withheld information that could have materially informed the investigation. Therefore, I believe this omission constitutes a contravention of section 55(10)(c), since the CPSO's role clearly qualifies as an "other benefit to the individual," and the custodian failed to account for the CPSO's legally established function in protecting patient interests and system integrity.

[50] In my view, section 55(10)(c) has no application to the circumstances of this complaint. Section 55(10) speaks to the custodian's duties upon granting a correction. Section 55(10)(b) specifically addresses the situation where the custodian has disclosed records to a third party that was subsequently corrected, which is not the case here. The

[13] See Circle of Care: Sharing Personal Health Information for Health-Care Purposes | Information and Privacy Commissioner of Ontario for information about the term "circle of care" which is commonly used to describe the ability of certain health information custodians to assume an individual's implied consent to collect, use or disclose personal health information for the purpose of providing health care.

custodian was not required to give the CPSO written notice of the corrections it granted as it made no previous disclosures to the CPSO.

The custodian's record keeping practices do not contravene the *Act*

[51] During mediation the complainant had questions relating to the custodian's record keeping practices and sought an explanation to the prevalence and causes of date issues contained in the records. The custodian did not dispute that errors had occurred in the records and agreed to make the relevant corrections. The custodian also confirmed that the errors was the result of a manufacturer setting and that a fix has since been performed by the manufacturer.

[52] In his representations, the complainant says that the method and manner the custodian corrected these errors is in contravention of section 11 of the *Act*. This section states:

> A health information custodian that uses personal health information about an individual shall take reasonable steps to ensure that the information is as accurate, complete and up-to-date as is necessary for the purposes for which it uses the information.

[53] In support of his position, the complainant says that the custodian "knowingly" used equipment[14] that recorded the incorrect date and time. The complainant says that the custodian's explanation that the errors occurred because of a manufacturer setting was not confirmed by the manufacturer. The complainant says that when he initially raised the date and time errors to the custodian, he was told that the fields could not be changed and no corrective action was taken until he filed a correction request under the *Act*. Finally, the complainant says that the manner in which the custodian corrected the time stamp errors conceal the errors. The complainant says this manner of correction "reflects poorly on record integrity and fails to meet section 11's standards for accuracy and accountability."

[54] In my view, the appellant's evidence does not raise issues which section 11(1) is intended to address. The duty to use accurate information under section 11(1) can be viewed as the corollary to the duty to correct inaccurate information under section 55(8).[15] I already provided by reasons as to why in the circumstances of this complaint, the complainant failed to discharge the onus in section 55(8).

[55] I also find that the appellant's evidence that the custodian was aware it was using equipment that recorded the incorrect date or time falls short of the type of evidence required to demonstrate that the custodian failed to meet its obligations under the *Act*

[14] Wavelight topography-Guided Ablation system.
[15] PHIPA Decision 36.

regarding its handling and security of personal health information.[16]

[56] Section 55(10)(a) is the provision which provides guidance in how corrections are to be made. If it is possible to record the correct information in the record, section 55(10)(a)(i) specifies that the incorrect information is to be struck out "in a manner that does not obliterate the record."[17] In the alternative, the custodian should make the correction in the record in a manner that informs the person accessing the record to view or trace the incorrect information. I have looked at the copy of the records the complainant provided this office and note that the dates appear to have been corrected to reflect the information requested by the complainant. However, in the copy of the record before me it does not appear that the incorrect information is visible.

[57] Section 55(10) constrains the type of orders adjudicators may make regarding correction of personal health information.[18] If an adjudicator were to conduct a review and found that there was a duty to correct the personal health information in the records, the adjudicator could only order the custodian to strike out the incorrect information in such a way that the original entry would remain legible.

[58] Though it appears that the custodian did not ensure that the original entry was visible in the copy of the records it provided to the complainant, I find that this issue alone does not warrant a review. Accordingly, I have decided to make no order in relation

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[16] See sections 12 and 13(1) of the *Act* which state:

> Section 12
> A health information custodian shall take steps that are reasonable in the circumstances to ensure that personal health information in the custodian's custody or control is protected against theft, loss and unauthorized use or disclosure and to ensure that the records containing the information are protected against unauthorized copying, modification or disposal.
> Section 13 (1)
> A health information custodian shall ensure that the records of personal health information that it has in its custody or under its control are retained, transferred and disposed of in a secure manner and in accordance with the prescribed requirements, if any.

[17] 55(10) states:

> Upon granting a request for a correction under subsection (1), the health information custodian shall,
> (a) make the requested correction by,
> (i) recording the correct information in the record and,
> (A) striking out the incorrect information in a manner that does not obliterate the record, or
> (B) if that is not possible, labelling the information as incorrect, severing the incorrect information from the record, storing it separately from the record and maintaining a link in the record that enables a person to trace the incorrect information, or
> (ii) if it is not possible to record the correct information in the record, ensuring that there is a practical system in place to inform a person who accesses the record that the information in the record is incorrect and to direct the person to the correct information.

[18] PHIPA Decision 258.

to this issue. In my view, there is no useful purpose in conducting a review to address the deficiency.

[59] Instead, this decision shall serve as a reminder to the custodian that any correction it makes to records containing the PHI of an individual should adhere to the requirements in section 55(10)(a). Accordingly, should the custodian receive a future request for a copy of the corrected records at issue in this complaint, even if the request is from the complainant, the copy produced should adhere to the requirements in section 55(10)(a).

Summary

[60] I exercise my discretion not to review the subject-matter of this complaint finding that there are no reasonable grounds to conduct a review (section 57(3)). In addition, I am satisfied that the custodian responded adequately to the correction request related to this complaint (57(4)(a)). In this regard, I note that the custodian exercised its discretion to make some of the corrections requested by the complainant and agreed to file statements of disagreement to the records.

[61] For the reasons set out above, I dismiss the complaint.

NO REVIEW:

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

Original Signed by: December 15, 2025

Jennifer James
Adjudicator