Information and Privacy Commissioner,
Ontario, Canada

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

PHIPA DECISION 318

Complaint HA24-00174

Vision Group

December 15, 2025

Summary: The complainant made a follow-up request to 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 as 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 317.

BACKGROUND:

[1] This decision addresses a complainant's follow-up request to correct records of his personal health information (PHI) under the *Personal Health Information Protection Act* (the *Act* or *PHIPA*) to Vision Group (the custodian).[1] In this request, the complainant

[1] The complainant's follow-up correction request is dated, March 25, 2024. The complainant's follow-up correction relates to the same record of personal health information at issue in Complaint HA24-00174. In Complaint HA24-00174, the complainant requested that LasikMD make 4 corrections to this medical records. The complainant disagreed with LasikMD's decision and filed a complaint with the Information Privacy Commission of Ontario (IPC) and complaint file HA24-00050 was opened, which was resolved by

asked the custodian to make eight corrections to medical records related to an eye procedure.[2] 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] The first correction request asked the custodian to reconcile differences the complainant says is contained in a pre-op report.[3] The custodian's correction decision denied the request saying that the pre-op details were updated on the day of surgery to include the measurements requested by the doctor.

[3] The second correction request asked the custodian to change the percentage number noted regarding his use of contacts and glasses.[4] The custodian's correction decision denied the request citing section 55(8) taking the position that the record is not incomplete or inaccurate for which it uses the information.

[4] The third correction request asked the custodian to adjust a number recording a depth measurement in the pre-op record.[5] The custodian's correction decision denied the request taking the position that the information the complainant seeks to correct is the doctor's professional opinion or observation.

[5] The fourth correction request asked the custodian to correct information in the treatment report as to whether an astigmatism was recorded.[6] The custodian's correction decision denied the request taking the position that the information the complainant seeks to correct is a professional opinion or observation.

[6] The fifth correction request asked the custodian to adjust a reading in a post op

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PHIPA Decision 317. It appears that during the exchange of correspondence between LasikMD and the complainant regarding his initial correction request, LasikMD's parent company Vision Group started to respond to the complainant's questions, which is likely why the complainant submitted his follow-up request to the parent company, the custodian in this complaint.

[2] 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*.

[3] The complainant says in his correction request that "Page 2 is very different from the same sheet provided to me on October 27th in the second visit of the day... There are multiple differences in the data. Please reconcile these differences."

[4] The complainant says in his correction request that "Page 2 shows my contact use as 10% and glasses use as 90%. This is misleading. I recall first being asked how much I use visual correction and I said 10%. Subsequently I was asked about a breakdown of contact vs glasses as a means to visual correction and 10% contacts and 90% glasses was my answer to that question. These numbers in my medical records should be 1% contacts and 9% glasses to more clearly reflect my answers."

[5] The complainant says in his correction request that "Page 9 the Surgical plan shows 'Ab Depth:19' while the PRK ablation depth was 24um. Assuming the surgical plan was adhered to would suggest that the 19 is an error."

[6] The complainant says in his correction request that on page 32 "'Correction: -1.44 D + 0.00 D x 0° / 12mm' indicates no astigmatism was corrected for but I paid for a custom wavefront and my (incorrectly dated) diagnostic scans (pg.34-39) showed astigmatism."

report alleging that it was not taken properly.[7] The custodian's correction decision denied the request stating that the measurement was taken using precise equipment.

[7] The sixth correction request asked the custodian to add a notation in the post op report and change a notation recording his satisfaction.[8] The custodian's correction decision denied the request taking the position that the information the complainant seeks to correct is a professional opinion or observation.

[8] The seventh correction request asked the custodian to add notations to a post op report.[9] The custodian's correction decision denied the requests citing section 55(8) taking the position that the record is not incomplete or inaccurate for which it uses the information.

[9] The eighth correction request asked the custodian to add notations to a post op report[10]. The custodian's correction decision denied the requests citing section 55(8) taking the position that the record is not incomplete or inaccurate for which it uses the information.

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

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[7] The complainant says in his correction request that on page 56 "'Refraction MR -0.25 -0.50 180' I believe this reading was not taken properly. I was told by a technician that 'we don't measure that' in reference to any +ve refractive errors. I believe [name of staff member] listed my refractive error as the smallest -ve myopic amount without considering a possibility I might have a +ve hyperopic error."

[8] The complainant says in his correction request that the following two items should be added to the medical record on page 57:

1. The patient questioned why he saw better at distance in right eye while wearing reading glasses. Explained to the patient that if he can see better with reading glasses it was due to presbyopia. Patient did not believe the presbyopia explanation.

2. "Happy" should be changed as the patient left the consult arguing with the technician about the presbyopia explaining the need for reading glasses at distance.

[9] The complainant says in his correction request that on "'Page 58 'Refractive MR +1.5' is missing from my records. I was told it wasn't included as +ve refractive errors are subjective and depend on the viewing distance from the eye. I left the consultation being told that I could try using +1.5 prescription reading glasses from the dollar store with one lens popped out instead of the +1.0 which I was then accustomed to."

[10] The complainant says in his correction request that the following additional notations should be added to the record on page 59:

> "Showed the patient the laser treatment portion of his medical records on the computer that he was angry about not receiving and informed him that sharing physical copies of these records is not allowed as per an agreement with the equipment manufacturer.", and
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> "Informed the patient that the presbyopia explanation as to why his reading glasses help him was incorrect and explained that reading glasses help because the epithelium heals into a mound in the middle of the eye, which temporarily changes the refractive error."

parties.

[11] 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 on the basis that the information constitutes a professional opinion or observation. The custodian also confirmed it continues to rely on section 55(8) to deny the 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.

[12] The custodian confirmed with the mediator that it considered the complainant's additional evidence but it continued to take the position that it is not required to grant the complainant's follow-up correction requests.

[13] The mediator's report also identified another issue the complainant raised during mediation[11]. The complainant had questions about the existence of two versions of the September 20th pre-op record.

[14] 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.

[15] 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 representation in response to my preliminary assessment before I made my final decision. The complainant submitted written representations in response.

[16] 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 (57(4)(a)).

DISCUSSION:

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

[17] 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

[11] The complainant also says 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. However, I addressed these issues in related PHIPA Decision 317. Accordingly, they will not be duplicated in this decision.

> 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.
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> (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;

[18] 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.[12]

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

[19] 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.

[20] 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.

[21] 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

[12] 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.

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)

[22] In all cases where a complaint regarding a custodian's refusal to correct records of personal health information (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).

[23] 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.

[24] 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 its professional observations or opinion, I must first determine whether the complainant has discharged the onus in section 55(8).

[25] 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.[13]

[26] 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.[14]

[27] As noted above, the complainant seeks the following corrections to the medical records:

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[13] PHIPA Decisions 36, 39 and 40.
[14] PHIPA Decisions 36 and 39.

- Reconcile the data differences he says appears on the same page provided to him at different times (first correction request),
- Change the percentage number reported in the records regarding his use of contacts and glasses (second correction request),
- Adjust the number recording a depth measurement (third correction request),
- Correct information as to whether an astigmatism was recorded (fourth correction request),
- Adjust a reading he says was not taken properly (fifth correction request),
- Add a notation in the records recording his eyesight after the procedure and his satisfaction level of the procedure (sixth correction request),
- Add a notation regarding the reflective level reported in the record (seventh correction request), and
- Add notations regarding information he says the custodian told him after the procedure was performed (eighth correction request).

[28] The complainant says the notations and measurements he has requested be corrected are inaccurate for the purpose for which the custodian uses the information "namely, determining surgical eligibility, documenting clinical assessments, supporting quality assurance and potentially defending clinical decisions or outcomes post hoc." For example, the complainant says that the information in the record "misrepresents" his actual vision habits and "could be used to justify or minimize the significance of a poor surgical outcome." The complainant goes on to state:

> … misrepresenting that I wore glasses 90% of the time could be cited to argue that a post operative full-time reliance on glasses after surgery is consistent with my baseline – even though I only wore them around 9% of the time prior to surgery. This type of misrepresentation undermines both clinical accountability and the integrity of any future assessment of harm.

[29] Attached to the complainant's representations was a medical opinion he obtained from an Ophthalmologist. I note that that this individual refers to himself, in the documentation provided by the complainant, as a medical expert witness in Ophthalmology. I have reviewed the opinion and note that the expert indicated that a procedural miscalculation or planning error related to reflective readings could explain the vision deterioration the complainant says he experienced after the procedure. The complainant says that he is seeking corrections to rectify missing or incorrect reflective readings in the records. The complainant also referenced two articles to demonstrate the importance of monitoring reflective measurements following the type of procedure he had.

[30] Having read and considered the entire complaint file, including the written representations the complainant submitted in response to my preliminary decision, I find that the complainant's evidence fails to establish a reasonable basis that the information he seeks to be corrected 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*.

[31] I maintain my view, expressed in the preliminary assessment, that corrections sought by the complainant 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 or not the "record is incomplete or inaccurate for the purposes for which the custodian uses the information".

[32] 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.[15] Here, the custodian's use of the records is to document the health care and services it says it provided to the complainant. The complainant says that the information in the records is missing important measurements or fails to explain the surgical outcome he experienced. In my view, the complainant's evidence describes his use of the records. Namely, his pursuit of a legal remedy to address the vision loss he says he experienced after the procedure.

[33] As I stated in PHIPA Decision 317, the health provider's use of a record need not mirror the patient's use. In fact, the *Act* contemplates different uses or purposes and requires health providers to add a statement of disagreement to any record in its custody which contains the PHI of a patient.

[34] As stated above, the custodian has already attached the complainant's statements of disagreement to the records.

[35] 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 records under section 55(8).

[36] Given my finding, it is not necessary that I 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.

Other Issue:

[37] As noted above, the complainant raised questions about the existence of two

[15] PHIPA Decision 36.

versions of the September 20th pre-op record.[16] In his representations, the complainant says he is unsatisfied with the custodian's response to the concerns about this report he raised during mediation.

[38] The complainant says that more than one version of this record was provided to him. The explanation the custodian provided during mediation is that the difference between the two versions is the result of its Electronic Medical Records system (EMR) automatically performing an update and an administrative error.

[39] In his representations, the complainant appears to take the position that this record should only contain pre-operation notations. He says that merging pre and post-operative notations in one record "undermines the credibility of the record-keeping process."

[40] The complainant also says in his representations that "[e]ven accepting that 'Pre-op combined' documents are system-generated for clinical convenience, the custodian has not explained":

> Why data referencing an October procedure appeared under a September appointment heading,
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> Why the document's title did not clearly denote it as a hybrid or merged record [and,]
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> Why this specific document was included in earlier disclosures and then silently omitted from later ones.[17]

[41] The complainant says that the existence of different versions of this record and the disappearance from subsequent disclosures "speak to a deeper issue with record integrity, accountability, and the adequacy of the custodian's handling of [personal health information]."

[42] The complainant goes on to state:

> The removal of this document, without notation, justification, or acknowledgement, may constitute a serious violation of [section 55(10) of the *Act*]. Whether this omission was deliberate or accidental, it demonstrates a failure to preserve the integrity and auditability of the record trail – a foundational requirement under health information law.

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[16] The complainant also had questions about the date reported in the October 11th Pre-op record but the custodian already agreed to correct this record in response to the complainant's initial January 10, 2024 correction request addressed in PHIPA Decision 317. Again, this issue will not be duplicated here.

[17] The complainant says that this record was provided to him with other records in October 2023 but was missing from the batch of records provided to him in March 2024.

> Preserving the history of the record is essential to allow independent scrutiny of discrepancies – such as the differential between the two versions of the September 20 record. Even if a patient retains the original version, they may lack the medical expertise to interpret the differences, and it would be inappropriate for them to speculate on their own. This makes it all the more important that prior versions are transparently maintained by the custodian. The disappearance of this record needs to be addressed before other issues can be fully considered, as it may provide important context for resolving additional ambiguities in the overall documentation.
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> …
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> The custodian's claim that "only one existing version of the medical record" remains raises further concerns. It implies that prior iterations – including the version I originally received – have been overwritten, deleted, or otherwise not preserved. If true, this would contradict the requirement under *PHIPA* to maintain a clear and transparent record of any correction, disputed or replaced health information.
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> Even if the [current] version reflects an "updated" record, that does not justify retroactively eliminating a previously disclosed, different version.

[43] The complainant references section 55(10) of the *Act*.[18] This provision provides guidance in how custodians are to make corrections to records of PHI. The requirements such as striking out incorrect information in a manner that does not obliterate the record or storing separately incorrect information removed from a record occur in situations where the custodian has granted a request for correction under section 55(1). That is not the situation here.

[44] The situation before me is that the complainant says that he has received two different versions of a record entitled "Pre-Op Detail (Appointment: 20-September)." The complainant takes the position that this record should not have been updated to include

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[18] Section 55(10) of the *Act* states:

> Upon granting a request for a correction under subsection (1), the health information custodian shall,
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> (a) make the requested correction by,
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> (i) recording the correct information in the record and,
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> (A) striking out the incorrect information in a manner that does not obliterate the record, or
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> (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
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> (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.

information gathered on October 11th. The complainant says that the *Act* requires the custodian to maintain separate records for the September 20th and October 11th appointments and that if they are merged the requirements in section 55(10) should be adhered to.

[45] The complainant's arguments also appear to allege that the type of "loss" contemplated in section 12 took place. The loss being that the custodian no longer has a copy of the original version of the pre-op detail that does not reference information gathered on October 11th. Section 12 states:

> 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.

[46] I have considered the complainant's submissions and find that evidence of an updated electronic medical record alone fails to establish that the custodian in the circumstances of this complaint contravened sections 12 or 55(10) of the *Act*. One, no loss occurred. The electronic record was updated when the custodian added a notation to the record. Two, section 55(10) does not provide guidance on general record keeping practices. This section only applies to situations in which the custodian has granted a correction request. The College of Physician and Surgeons (CPSO) publishes medical records management policies which sets out its expectations for physicians with custody or control of medical records. I am not aware of any requirement under the *Act* that requires the custodian to maintain the pre-op record in the manner suggested by the complainant.

[47] Having regard to the above, I find that there are no reasonable grounds to review the complainant's concerns related to having received two versions of the September 20th pre-op record. In any event, the custodian provided an explanation in response to the complainant's concerns about this record during mediation.

Summary

[48] 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 provided the complainant with an explanation where it determined it was not required to make the requested correction under the *Act*.

[49] 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