Information and Privacy Commissioner,
Ontario, Canada

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

PHIPA DECISION 326

Complaint HA23-00094

The Ottawa Hospital

January 26, 2026

Summary: The complainant submitted a correction request to the Ottawa Hospital, seeking corrections to portions of an after-visit summary. The complainant later submitted a statement of disagreement, asking that it be added to his records pursuant to section 55(13) of the *Personal Health Information Protection Act* (*PHIPA*). The hospital denied the correction request on the basis that it did not have a duty under section 55(8) of *PHIPA* to make the requested corrections but added the statement of disagreement to the records it held within its electronic health records system.

In this decision, the adjudicator upholds the hospital's refusal to correct the after-visit summary, finding that the hospital did not have a duty to do so under section 55(8). The adjudicator also finds that the hospital fulfilled its section 55(13) obligation by attaching the statement of disagreement to the patient's electronic health record and that it was not required to make the statement accessible via the patient portal. She dismisses the complaint.

Statutes Considered: *Personal Health Information Protection Act, 2004,* S.O. 2004, c. 3, Sched. A, sections 3(1), 4(1), 55(1), (8), (9), (11), (12), and (13).

BACKGROUND:

[1] The complainant made a correction request under section 55(1) of the *Personal Health information Protection Act* (*PHIPA*) to the Ottawa Hospital (the hospital). The request set out the complainant's disagreements with notes and statements made by a doctor (the doctor) in an "After Visit Summary" (the Summary).

[2] The hospital denied the correction request on the basis that it did not have a duty to make the corrections under section 55(8) of *PHIPA* and also on the basis that the exception to the right of correction at section 55(9)(b) of *PHIPA* applies. In the denial letter, the hospital outlined the complainant's right to prepare a statement of disagreement to be attached to his health record.

[3] The complainant filed a correction complaint with the Information and Privacy Commissioner of Ontario (IPC). During mediation of the complaint, the complainant advised that he had provided the hospital with a statement of disagreement. The complainant stated that when he accessed his records through MyChart, a portal through which patients can view their medical records, he was not able to view the statement of disagreement.

[4] In response, the hospital confirmed that it added the statement of disagreement to the complainant's records but noted that it could not be accessed through MyChart. The hospital stated that if the complainant made a request for the relevant records through the hospital's Release of Information Department, the statement of disagreement would be provided with those records. The hospital otherwise maintained its decision not to make the requested corrections to the Summary.

[5] As mediation did not resolve the complaint, it was moved to the adjudication stage of the complaints process, where an adjudicator may conduct a review. As the adjudicator assigned to the complaint file, I decided to conduct a review. I sought and received representations from both the hospital and the complainant.[1]

[6] In this decision, I find that the hospital does not have a duty under section 55(8) to make the requested corrections to the Summary, as the information is not incomplete or inaccurate for the purposes for which the hospital uses the information. I also find that the hospital fulfilled its section 55(13) obligation to add the statement of disagreement to the complainant's records of personal health information that it holds, and therefore, is not required to make the statement of disagreement accessible via MyChart. I dismiss the complaint.

RECORDS:

[7] The record at issue is a two-page report titled "After Visit Summary" from a hospital visit that occurred on September 19, 2022.

[1] Representations were shared in accordance with the IPC's *Code of Procedure for Matters under the Personal Health Information Protection Act, 2004*.

ISSUES:

A. Does the hospital have a duty to make the requested corrections under section 55(8) of *PHIPA*?

B. Was the hospital required under section 55(13) of *PHIPA* to make the statement of disagreement accessible within MyChart?

DISCUSSION:

Issue A: Does the hospital have a duty to make the requested corrections under section 55(8) of *PHIPA*?

[8] There is no dispute between the parties, and I find, that the hospital is a health information custodian as defined in section 3(1) of *PHIPA*. I also find that the Summary contains the complainant's personal health information, as defined under section 4(1) of *PHIPA*.

[9] The complainant's requested corrections relate to two statements that the doctor included in the Summary. The complainant asked that these statements be removed, describing the doctor's comments as "unprofessional, prejudicial, and false comments that do not serve the purpose of an after-care summary."

[10] These two statements are:

> • "[The complainant] has been very angry that he has been waiting in the ER for the past couple of hours"; and
>
> • "Patient is simply angry with me for not coming back earlier to let him know the plan, and threatening to make complaint."

[11] Section 55(1) of *PHIPA* 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.

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

[13] This right is subject to the exceptions set out in section 55(9) of *PHIPA*, which states:

> Despite subsection (8), a health information custodian is not required to correct a record of personal 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.

Representations of the Parties

Hospital's representations

[14] The hospital takes the position that the exceptions at both 55(9)(a) and 55(9)(b) apply to the statements at issue.

[15] The hospital states that the doctor created the Summary, and therefore it is the doctor, and not the hospital, that has the knowledge, expertise, and authority to correct it. In particular, the hospital notes that it is the doctor who has the knowledge of what occurred between him and the patient. As the doctor has not approved the requested correction, the hospital states that the section 55(9)(a) exception applies.

[16] The hospital also states that the section 55(9)(b) exception applies to the relevant statements in the Summary. The hospital's position is that the information at issue describes the doctor's assessment, the advice he gave to the complainant, and the reason that the complainant gave for leaving, all of which are professional opinions or observations.

[17] The hospital states that the record must reflect the observation of the professional at the time the observation was recorded, rather than afterwards or in hindsight.[2] In regard to the discrepancy between the wait times observed, the hospital states that from the doctor's perspective at the time he spoke to the complainant, "a couple hours" had passed since he first saw him.

[18] The hospital argues that that the complainant has not met the burden of establishing an absence of good faith on the part of the doctor, and so the presumption that the professional opinions or observations were made in good faith applies. The hospital states that the doctor used objective, dispassionate language in documenting the complainant's behaviour. The hospital further states that the complainant's threat to

[2] PHIPA Decision 131.

make a complaint was an accurate statement that the doctor believed was relevant.

[19] The hospital also argues that the complainant has not met the conditions to establish a duty to correct under 55(8). The complainant's objection to the doctor documenting his threat to make a complaint centres around this being a private statement that ought not to be in a medical record. However, the hospital states that the complainant's position does not establish that the statement, as documented, is inaccurate. Regarding the "couple of hours" documented by the doctor when the patient waited longer, the hospital states that not all information in records needs to be accurate in every respect.[3] The hospital states that it used the Summary to communicate that the complainant left against medical advice and to set out how that may impact his care. The hospital's position is that the exact time that the complainant waited is not relevant to that purpose and therefore, the hospital is not obliged to make the correction requested.

Complainant's representations

[20] The complainant states that the hospital set out that the purpose of an after-visit summary is describing what happens during a visit and what information may be needed for future care. However, the complainant argues that the doctor included statements that did not serve this purpose, and were "unprofessional, prejudicial, and false." This includes the doctor's statement describing the complainant as "very angry that he has been waiting in the ER for the past couple of hours." The complainant states that, in addition to the timeframe being incorrect, the doctor acted in bad faith by including this statement in the summary. The complainant stated that the doctor's choice to do so was "an attempt at establishing a narrative against a complaint," rather than documenting a professional observation.

[21] Regarding the other statement, describing the complainant as angry and threatening to make a complaint, the complainant states that this was "reckless and needless disclosure" that did not serve the stated purpose of the after-visit summary. The complainant states that it could contribute to a serious bias against him as a patient by other medical professionals. The complainant also clarified that he said that his experience at the emergency department would warrant a complaint, rather than stating that he would be making a complaint.

[22] The complainant also takes the position that the exception at section 55(9)(a) does not apply. Based on his understanding of the correction process, the complainant made his correction request to the doctor, via his representation at the hospital.

Analysis and findings

[23] Depending on the nature of the correction request, the information that the individual seeks to have corrected, and the reasons for the custodian's refusal of the request, the IPC may approach the analysis in a correction complaint initially under

[3] PHIPA Decision 103.

section 55(8) or 55(9).[4] In this case I will begin by determining whether the hospital has a duty to make the corrections at issue under section 55(8). If the hospital does, I will then address whether the exceptions at sections 55(9)(a) and (b) apply to the corrections at issue.

Section 55(8): right of correction to records of an individual's personal health information

[24] Based on the evidence before me, I find that the complainant has not demonstrated that the statements regarding his state of mind or threats to make a complaint are inaccurate. I do not dispute the complainant's recollection that if he was angry, it was for different reasons that those documented, or that he may have made a more nuanced reference to making a complaint. However, under section 55(8), once health information has been documented, it is the individual who must demonstrate that the record is inaccurate for the purposes for which the custodian uses the information. In this case, the record at issue documents an interaction between the complainant and the doctor. The complainant has provided his viewpoint of that interaction, in contrast to what the doctor documented. However, this description on its own is not sufficient to demonstrate that the documented information is inaccurate.

[25] In addition, the complainant has raised that the descriptions provided are irrelevant for the purposes of an after-visit summary and cited this as a reason that they should be corrected. The complainant notes that the hospital described the purpose of an after-visit summary as "[informing] the patient about what happened during a visit and what information they may need for future care, such as discharge instructions." The hospital provided its view of the purpose of the Summary at issue in this case, stating that it used the after-visit summary "to communicate to [the complainant] that he left against medical advice and how that may impact his care."

[26] Based on these descriptions, the complainant and the hospital broadly agree that the hospital uses the information in an after-visit summary for the purposes of providing health care to the complainant. While the complainant's position is that statements regarding whether he was angry, the reasons for his anger, and possible threats to make a complaint are not relevant for the purposes of providing health care, this lack of relevancy does not establish a right of correction under section 55(8). Rather, this supports that the complainant has not met the test for correction under section 55(8), as he has not established that the statements are not inaccurate *for the purpose for which the hospital uses the information* – namely, the provision of health care.

[27] In summary, the complainant has not demonstrated that the information at issue is incomplete or inaccurate, and I am not satisfied that the information is relevant to the purposes that the hospital uses the information. I therefore find that the hospital has no duty to correct the record under section 55(8) of *PHIPA*.

[4] PHIPA Decision 36.

Issue B. Was the hospital required under section 55(13) of *PHIPA* to make the statement of disagreement accessible within MyChart?

[28] When a health information custodian refuses a request for correction, it must include certain information in the notice of refusal, as specified in section 55(11). Relevant to the present matter is section 55(11)(b):

> 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,
>
> […]
>
> (b) 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.

[29] Under section 55(12), the requester has a corresponding right to take the actions outlined in section 55(11).[5] Section 55(13) sets out the duty of the custodian in such instances, stating that "[if] the individual takes an action described in clause (11) (b) […], the health information custodian shall comply with the requirements described in the applicable clause."

Representations of the Parties

Hospital's representations

[30] The hospital states that when it receives a statement of disagreement, it scans that document into Epic, the health information system it uses. The statement of disagreement is attached to the relevant record and is provided with that record when the hospital receives a request for a patient's records via the Release of Information department.

[31] MyChart is a portal that patients can use to view some of their personal health information. MyChart automatically populates certain information from Epic; that information is available to the patient via MyChart. However, the hospital states that MyChart does not automatically populate all patient documents. Instead, system-wide rules set out which documents are populated from Epic to MyChart. At present, these rules do not include uploading statements of disagreement to MyChart, and the hospital states that it is unable to import a single document, such as the complainant's statement

[5] Section 55(12) of *PHIPA* states:

> If a health information custodian, under subsection (3) or (4), refuses a request for a correction under subsection (1), in whole or in part, or is deemed to have refused the request, the individual is entitled to take the actions described in any of clauses (11) (a), (b), (c) and (d).

of disagreement. Therefore, the hospital states that for the complainant's statement of disagreement to be accessible in MyChart, it would have to change the rules such that all scanned documents for all patients are uploaded into MyChart.

[32] The hospital's position is that it has met its obligations under section 55(13), as it attached the statement of disagreement to the complainant's medical records, and this statement is disclosed with those records when the hospital receives a request for them via the Release of Information department. The hospital notes that the complainant may ask for a copy of his records, including the attached statement of disagreement, through the hospital's Release of Information department.

Complainant's representations

[33] The complainant states that the hospital only informed him that the statement of disagreement would not be accessible via MyChart after he submitted it. The complainant states that he has since stopped using MyChart and is now accessing his medical records by applying for them and paying the associated fees.

[34] The complainant seeks to have statements of correction integrated into medical records that are available to patients via online portals and third-party applications used by the hospital. The complainant states that expanding access to these statements of disagreement would fully respect a patient's rights under *PHIPA*.[6]

Analysis and findings

[35] Under sections 55(11) and 55(13), health information custodians are required to "attach the statement of disagreement as part of the records that it holds of the individual's personal health information." Custodians are also required to "disclose the statement of disagreement whenever the custodian discloses information to which the statement relates."

[36] The dispute between the parties is whether the hospital has fulfilled its section 55(13) obligation by adding the statement of disagreement to Epic, or whether it is also required to add this statement of disagreement to MyChart.

[37] As part of his representations, the complainant included information from the frequently asked questions page of MyChart. This page states what information patients can and cannot access within MyChart. It also states that "MyChart is designed to help you access certain records that provide the most value" and stipulates that "[your] MyChart information comes directly from your electronic medical record at your hospital."

[6] Failing this expanded access to statements of disagreement, the complainant requests that the IPC instruct the hospital to provide clear information on its website setting out any limitations on how statements of correction are integrated into records. However, my review of this matter is limited to consideration of the hospital's decision to deny the correction request and whether the hospital has met its obligation to attach the statement of disagreement as required under section 55(13). The hospital's notice provisions are not before me in this review.

This is consistent with the hospital's description of MyChart as populating some patient information so patients can more easily access it.

[38] Having reviewed the representations of the parties, as well as the online information submitted by the complainant, it is my view that MyChart is a service provided to patients to allow them to have easier access to their own personal health information. The information within MyChart is separate and distinct from the records of personal health information held by the hospital that are subject to access requests under section 52(1) and correction requests under section 55(1).

[39] On this basis, the hospital is not required under section 55(13) to add the complainant's statement of disagreement to the records accessible to the complainant via MyChart. I find that the hospital has satisfied its section 55(13) obligations by attaching the statement of disagreement to the Summary within Epic and ensuring that the statement of disagreement is provided when the hospital receives a request for the Summary via its Release of Information department.

NO ORDER:

For the foregoing reasons, no order is issued.

Original Signed by: January 26, 2026

Jennifer Olijnyk
Adjudicator