Information and Privacy Commissioner,
Ontario, Canada

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

PHIPA DECISION 327

Complaint HA23-00086

Children's Hospital of Eastern Ontario (CHEO)

January 28, 2026

Summary: A father requested that a hospital make corrections to an emergency report made after his daughter was brought to the emergency room by her mother.

In this decision, the adjudicator upholds the hospital's decision to deny the correction request on the ground there is no duty to correct. She upholds the hospital's decision and dismisses the complaint.

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

OVERVIEW:

[1] This decision addresses a father's request[1] under the *Personal Health Information Protection Act, 2004* (*PHIPA* or the *Act*) to correct his daughter's emergency report (EMR) completed by a physician at Children's Hospital of Eastern Ontario (the hospital or custodian).

[2] The father's correction request asked the hospital to correct information in the EMR which describes the reason his daughter attended the emergency room. He

[1] In the circumstances of this complaint, there is no dispute between the parties that the records contain the "personal health information" of the complainant's daughter as defined in section 4(1) and that he is entitled to make requests under *PHIPA* on his daughter's behalf.

explained that he was not present during his daughter's visit to the emergency room as she was brought by her mother and that he was only aware of his daughter having a sore throat.

[3] The hospital issued a decision denying the father's correction request citing section 55(9) of *PHIPA*. In its decision, the hospital states:

> … the physician states that there are no corrections, as this was his assessment at the time during the appointment and there was no mention of a sore throat in the visit. The physician documented according to what was disclosed during the assessment as it was relevant to a fall with a head injury.

[4] The father, now the complainant, filed a complaint with the Information and Privacy Commission of Ontario (IPC) requesting a review of the hospital's decision.

[5] A mediator was assigned to explore settlement with the parties, but no settlement was reached. The file was subsequently moved to the adjudication stage of the complaint process in which an adjudicator may decide to conduct a review. The adjudicator invited the parties to submit written representations in support of their positions and the file was subsequently transferred to me for completion.

[6] After reviewing the written representations of the parties, the file contents along with the EMR, I find that the complainant's evidence does not discharge the onus in section 55(8). As a result, I find that the hospital does not have a duty to correct the EMR.

RECORD:

[7] The record at issue is an Emergency Room Report, dated February 5, 2023.

DISCUSSION:

[8] The sole issue in this complaint is whether the hospital has a duty to make the requested corrections under section 55(1) of *PHIPA*.

[9] Section 55(1) 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.

[10] 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.

[11] If the requirements of section 55(8) are established, the question becomes whether any of the exceptions that are set out in section 55(9) apply. In the circumstances of this complaint, the hospital 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.

[12] 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).

[13] 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.

[14] If the above is established, the question becomes whether any of the exceptions that are set out in section 55(9) apply. Accordingly, before I consider the hospital'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).

[15] 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.[2]

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[2] PHIPA Decisions 36, 39 and 40.

[16] 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.[3]

[17] For the reasons that follow, I find that the complainant's evidence does not discharge the onus in section 55(8) and dismiss the complaint.

Submissions of the parties

[18] In his request, the complainant says that the information his daughter's mother provided the attending physician was "inaccurate and incomplete."

[19] The complainant says that on the day his daughter attended the hospital, she had previously been in his care. He said that after he dropped his daughter off with her mother, he sent the mother a text to make her aware that his daughter had told him that her neck was sore. He said that the mother responded that the daughter told her that her head hurt and that she was going to take her to the hospital. He says that the day after the mother told him that his daughter was diagnosed with a concussion.

[20] The complainant says that he filed a correction request because the EMR report indicates that his daughter was "presenting with … a head concussion." The complainant says that the physician's diagnosis was based on inaccurate and incomplete information provided by his daughter's mother. In addition, the complainant disputes the notations in the EMR that state his daughter had a fall and questions why the report does not mention her sore throat.

[21] The complainant suggests that his daughter's mother provided hospital staff with incorrect information to obtain a medical report which could be used to her advantage in ongoing custody proceedings.

[22] In its representations[4], the hospital takes the position that it does not have a duty to make the requested corrections. In support of its position, the hospital states:

> The physician in this case has indicated that there was no mention of a sore throat at triage in the Emergency Department, and this was not recorded or reported as the presenting complaint. The Physician has indicated that only the mother was present at this visit providing information and that he would "only change my own entry if I could reliably recall specific details that had been omitted."

[3] PHIPA Decisions 36 and 39.
[4] The hospital provided copies of its correspondence with the physician along with its communications with the complainant.

> [The physician] has indicated that the presenting complaint was related to a head injury, which is what he treated the patient for and documented in the electronic health record accordingly.
>
> At the time of treatment, [the physician] was not presented with any other information to indicated that the information provided was inaccurate or incomplete.

[23] The complainant was given an opportunity to submit written representations in response to the hospital's representations. In response, the complainant maintains that his daughter did not fall or hit her head the day in question. He says that the physician's diagnosis that his daughter had a concussion was entirely based on information the mother provided. He asserts that there is no basis for the diagnosis as the EMR itself reveals that the physician did not observe any trauma, bruising or cuts on his daughter.

[24] The complainant refers to his evidence that his daughter did not fall as "new information" that should have been brought to the physician's attention. The complainant states "… with this new information coming to light, and with the existing notes made by the [physician] confirming [my daughter's] healthy status, this should be enough to indicate that the information provided was inaccurate." In addition, the complainant says that the fact that physician did not document any visible injuries to his daughter establishes that "there was no concussion."

[25] The complainant also provided copies of his communication with the hospital with his representations presumably as evidence that he provided the hospital with the necessary information to make the correction requested.

Decision and analysis

[26] The issue to be determined in this complaint is whether the EMR contains information which is *incomplete or inaccurate for the purposes for which the hospital uses the information* not whether the complainant agrees with the notations contained in the report.

[27] As noted above, section 55(8) provides that 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."

[28] The EMR is a computer-generated document containing information relating to the complainant's daughter's emergency hospital visit. The triage notes indicate that hospital staff were told that the complainant's daughter hit her head and experienced a headache and vomiting. The attending physician examined the complainant's daughter and discharged her. The complainant says that the notations in the EMR concluding that his daughter had a concussion were the result of the physician being provided incomplete or inaccurate information by his daughter's mother.

[29] In my view, the information that the complainant wants corrected has no impact on the purposes for which the hospital uses the information. The hospital's use of the record before me is to summarize the complainant's daughter's visit to the emergency department and document what examinations took place along with the physician's conclusions and plans for her discharge.

[30] In this case, the complainant's daughter attended the ER with her mother who provided answers in response to inquiries made by hospital staff. There is no dispute that the complainant did not attend the hospital during the time his daughter received care. However, he disagrees with some of the information the mother provided staff and asks that the report be changed to reflect what he says occurred the day in question. However, the purpose of the EMR is not to document what the complainant says occurred, but what the hospital was told and acted upon.

[31] Accordingly, I find that the complainant's evidence does not demonstrate that the EMR is incomplete or inaccurate for the purposes for which the hospital uses the information. As a result, I find no reasonable basis to support a finding that the complainant has discharged the onus in section 55(8). Accordingly, I find the hospital does not have a duty to correct the information under section 55(8).

[32] Given my findings, it is not necessary to determine whether the complainant gave the hospital the information necessary to enable it to correct the record. 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.

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

Original Signed by: January 28, 2026

Jennifer James
Adjudicator