Information and Privacy Commissioner,
Ontario, Canada

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

PHIPA DECISION 329

Complaint HA25-00030

A physician

January 29, 2026

Summary: The complainant, a former patient, sought review of a physician's decision to deny her request under the *Personal Health Information Protection Act, 2004* to correct records from 2007 and 2008. The physician declined to make the requested corrections on the basis that the records had been destroyed more than ten years after he ceased providing care to the complainant. The adjudicator finds that the requirements for correction under section 55(8) are not met because the physician no longer uses the information. The adjudicator also finds that the physician responded adequately to the request and declines to review the matter under section 57(4).

Statutes Considered: *Personal Health Information Protection Act, 2004* S.O. 2004, c. 3, Sched. A, sections 57(3), 57(4)(a), 55(8), 55(9)(b), 55(11); and O. Reg. 114/95 under the *Medicine Act, 1991*, S.O. 1991, c. 30, section 19.

BACKGROUND:

[1] This matter arises from a complaint about a physician's refusal to correct records of personal health information under the *Personal Health Information Protection Act, 2004* (*PHIPA*).

[2] In April 2024, the complainant submitted a written correction request to her former physician regarding two progress notes from 2007 and 2008, and a 2008 referral letter. She claimed that the records contained misleading and inaccurate gynecological details. The complainant provided the physician with redacted copies of the records, with

associated dates and additional information, and asked the physician to prepare a written "medical report" to be placed in her file to inform future healthcare providers.

[3] In his initial response in August 2024, the physician disagreed with the complainant's assertions. He explained the records' contents, and informed her of her right under *PHIPA* to submit a statement of disagreement that could be appended to the records. He offered to add a note reflecting the complainant's disagreement, to communicate directly with her new specialist about her concerns, and also asked the complainant for unredacted copies of the records.

[4] The complainant then filed a complaint with the Information and Privacy Commissioner (IPC). She explained in her complaint that she was not looking for the physician's explanation about the contents of the records, but rather a correction to information she believes is "inaccurate, and outdated and therefore misleading to anyone reading it, especially a surgeon consultant."

[5] A mediator was assigned to explore resolution with the parties. During mediation, the physician provided a revised response: he advised that he had revisited the complainant's request and determined he could not make the requested corrections because he no longer has the records. He explained that the complainant's last appointment was in April 2011 and that the records were destroyed in accordance with section 19(1) of Ontario Regulation 114/94 under the *Medicine Act, 1991*,[1] which allows for destruction of patient records ten years after the last clinical contact.[2]

[6] The complainant, meanwhile, stated that she had obtained copies of the records from the physician over ten years ago and only became aware of the alleged inaccuracies after a specialist reviewed her electronic medical records in 2023.

[7] When not resolved in mediation, the complaint moved to adjudication where an adjudicator may conduct a review under *PHIPA*.

DISCUSSION:

[8] Under section 57(3), the IPC may review the subject-matter of a complaint if satisfied that there are reasonable grounds to do so. Section 57(4) gives the IPC discretion not to review a complaint for any reason it considers proper, including where the physician has responded adequately.[3]

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[1] S.O. 1991, c. 30.

[2] Section 19(1) of O.Reg. 114/94 states: "A member shall retain the records required by regulation for at least ten years after the date of the last entry in the record, or until ten years after the day on which the patient reached or would have reached the age of eighteen years, or until the member ceases to practice medicine, whichever occurs first, subject to subsection (2)."

[3] Under section 57(4)(a). Section 57(4(a) states that the "Commissioner may decide not to review the subject-matter of the complainant for whatever reason the Commissioner considers proper, including if

[9] Section 55(8) describes when a physician must grant a request for correction. It 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.

Section 55(9)(b) sets out an exception to this duty to correct, where the record consists of a professional opinion or observation made in good faith. It states:

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

[10] Read together, sections 55(8) and (9) set out when an individual is entitled to a correction of a record of their personal health information, and when they are not.

Preliminary assessment not to conduct a review

[11] After examining the materials in support of the complaint and considering the relevant legislative provisions, I made a preliminary assessment that the complaint does not warrant a review under *PHIPA*. I sent the complainant a letter setting out my preliminary assessment that the test for correction in section 55(8) was not met, and that the physician had responded adequately to the request. I also explained that, even if the test for correction was met, it was my preliminary assessment that the exception in section 55(9)(b) to the duty to correct in section 55(8) applied, because the personal health information consists of the physician's professional opinion or observations, and there was no evidence that they were made in bad faith at the time. I invited the complainant to provide representations if she disagreed with my preliminary assessment.

The complainant's representations

[12] The complainant submitted representations reiterating that the referral letter and progress notes contain false and misleading information. She explains that the correction request is concerned with her gynecological history, and the referral letter gives an inaccurate impression of her gynecological health at that time. She reiterates that the correction request was prompted after a specialist accessed the 2008 referral letter in 2023, without the complainant's knowledge, and relied on it to prepare documentation about her care. The complainant expresses concern about physicians relying on outdated

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satisfied that, (a) The person about which the complaint is made has responded adequately to the complaint."

or misleading information, especially without her knowledge, and argues that she should have been informed if the records were going to be used by the specialist.[4]

[13] The complainant declined the physician's offer to communicate directly with her current specialist, stating that she no longer trusts the physician and does not want him speaking on her behalf. She challenges the physician's explanation for the records' destruction, claiming she was told that the records were lost in storage when the physician closed his practice.

[14] The complainant does not address either the requirement under section 55(8) that the physician must use the information, or my preliminary assessment that the physician no longer uses the information because he is no longer involved in her care.

No reasonable grounds to conduct a review

[15] As set out above, section 55(8) requires that a correction be made only if the person asking for correction demonstrates to the physician's satisfaction that the record is "incomplete or inaccurate for the purposes for which the [physician] uses the information." In this case, the physician has not used the information since he ceased providing care to the complainant in 2011 at the latest (or 2010, as the complainant submits). The records at issue are not in current use and are no longer part of the physician's active practice or records. As such, the duty to correct in section 55(8) is not engaged.

[16] The complainant's concerns focus largely on the recent effects of the records' contents, particularly the impact she believes the referral letter had on a subsequent health care encounter. While I do not question the seriousness of those concerns, the correction provisions of *PHIPA* apply to the physician's own use of the personal health information. *PHIPA* does not provide a right to correction based on how other health care providers may later interpret or rely on the information.

[17] Even if the duty to correct in section 55(8) were engaged, I would find that the exception in section 55(9)(b) applies. Based on the nature of the records, I am satisfied that they reflect the physician's professional opinion or observations made in the course of providing care. There is no evidence before me to suggest that the physician acted in bad faith, with malice, or with serious carelessness or recklessness in preparing the records.[5] In the absence of such evidence, section 55(9)(b) would apply and relieve the

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[4] The complainant relies on the *Health Care Consent Act, 1996* to emphasize the right of patients to participate in decisions about their care. She argues that the inclusion of inaccurate information in the referral letter affected how she was treated by a consulting surgeon, affected her ability to make informed decisions, and has caused ongoing personal harm. These issues, which concern broader matters of consent and clinical decision-making, are not before me and I do not address them in this decision.

[5] Courts have held that a lack of good faith may be established by evidence of malice or intent to harm, or serious carelessness or recklessness. The courts have also stated that individuals are presumed to act in good faith unless proven otherwise. The burden of proof lies with the complainant to establish that the

physician of the section 55(8) duty to correct the records.

[18] I also have no basis to conclude that the physician acted improperly in destroying the records. The evidence before me from the physician is that the records were destroyed ten years after his last clinical contact with the complainant. The custodian confirmed that this was done in accordance with statutory retention requirements. The complainant disputes some of the circumstances surrounding the destruction, but provides no evidence that statutory requirements were not followed. The physician responded adequately to the correction complaint by advising that the records were destroyed in accordance with statutory requirements.

[19] In conclusion, I find that the complainant has not established that the requirements for correction under section 55(8) are met. The records at issue are no longer used by the physician, who ceased providing care to the complainant approximately 15 years ago. As section 55(8) applies only where the physician uses the information, the duty to correct does not arise in these circumstances. I am also satisfied that the physician destroyed the records in accordance with applicable retention requirements and adequately responded to the correction request. As a result, I find there are no reasonable grounds to review the complaint under section 57(3), and I decline to conduct a review under section 57(4) of *PHIPA*.

NO REVIEW:

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

Original signed by: January 29, 2026

Jessica Kowalski
Adjudicator

opinion or observation was not made in good faith. (see *Finney v Barreau du Québec*, [2004] 2 SCR 17, 2004 SCC 36 (CanLII))