# eCHN Privacy Complaint Form

Version 1.0 (March 17, 2016 )

## Form Completion Instructions

1. Please fully read this form.
2. Please enter all information as requested.
3. Sign and submit this form to the eCHN Privacy Office.

## Part 1 – Submitting a Request for Access

The electronic Child Health Network (eCHN) provides services to enable health information custodians[1] to use electronic means to share personal health information with other health information custodians for the purpose of providing care to paediatric patients. The personal health information contained in the eCHN databases represents a copy of the data found in the originating health information custodians' records and continues to be in the custody and control of the contributing health information custodian. eCHN cannot disclose any personal health information directly to a patient or a patient's guardian.

Please note that by providing this completed form to eCHN, you consent to eCHN using the information provided, to investigate and resolve your complaint. This form may be shared with the original health information custodian that contributed data to eCHN if necessary to address the items within the complaint. eCHN will retain a copy of this form for 7 years, as part of the privacy complaints procedure. This information shall be safeguarded in accordance with the eCHN Security Policy and will not be used for any secondary purpose.

eCHN will respond to all complaints received at the eCHN Privacy Office within 30 of receipt. If eCHN cannot address the issue outlined in the complaint within 30 days the eCHN Privacy Office will contact the individual submitting the complaint and advise them of when they can expect to receive a response.

## Part 2 – Patient Information *(if applicable)*

| First Name * | Middle Name * | Last Name * |
|---|---|---|
| Address | | Unit No. |
| City | Province | Postal Code |

## Part 3 – Information of the Individual Submitting the Complaint

| Salutation Mr. Miss Mrs. Ms. | First Name * | Middle Name * | Last Name * |
|---|---|---|---|
| Relationship to Patient | Business Telephone * *(incl. Extension)* | Business Mobile Number | Business E-mail* |

☐ I consent to being contacted at this email address or through the email address of my named representative. I acknowledge that sending personal information over the Internet is not secure as the email can be intercepted and/or manipulated and retransmitted.

[1] Health Information Custodian, means a person or organization as described in the *Personal Health Information Protection Act*, 2004 section 3 and who has custody or control of personal health information as a result of or in connection with performing the person's or organization's powers or duties. Some Health Information Custodians that participate in eCHN include independent health care practitioners, Community Care Access Corporations, Hospitals, Community Health Centres and other authorized health care organizations.

Please indicate your association with the patient:

- ☐ Parent
- ☐ Legal Guardian
- ☐ Self (it is my paediatric health record being requested)
- ☐ Lawyer *(Please provide name of Company):*

  _____

- ☐ Other *(Please indicate):*

  _____

## Part 4 – Details of the Complaint

Please provide a detailed description of your privacy complaint:

_____

_____

_____

_____

_____

## Part 5 – Authorization

_____ _____

Signature of Individual Submitting the Complaint Date

**** Please submit the completed form to the eCHN Privacy Office:**

The electronic Child Health Network
180 Dundas Street West, Suite 2405
Toronto, Ontario
M5G 1Z8

Fax: 416 813 8294
privacy@echn.ca