

I N S T R U C T I O N S

This form is to be completed by a person who believes there is an error in his/her clinical record. Copies of this form must be provided to the:

- Chief Executive Officer, Whitehorse General Hospital; and
- physician.

IN THE MATTER OF *the Mental Health Act*

AND IN THE MATTER OF _____
Name of applicant

It is my opinion that the following portions of my clinical record are incorrect

I believe the correct facts to be _____

I therefore request that my clinical record be corrected.

DATED at _____, }
this _____ day of _____, _____ }
month year }
SIGNATURE OF APPLICANT
PRINTED NAME OF APPLICANT