

Request to Change Psychiatric Records

Tel: 905-780-1470 **Fax**: 647-699-9812 **Email:** help@psychotherapymatters.com

Patient Information:		
First Name:	Last Name:	
Date of Birth:(YYYY-MM-DD)	Phone Number:	
Street Address:		
City:	Province: Postal Code:	
Email Address:		
Communication Preferences:		
Can Psychotherapy Matters email the address listed above? Yes		
Can Psychotherapy Matters leave a message at the phone number listed above? Yes No		
Report Source of Records:		
This report was provided to me by:		
☐ Psychotherapy Matters or psychiatrist directly ☐ Family doctor or nurse practitioner		
□ Other: (please specify)		

NOTE: You have the right to request changes to your personal health information held by Psychotherapy Matters. Psychotherapy Matters has the right to deny changes if they are not significant and/or clinically relevant to your care.

Requested Changes: Please describe the information you would like to change and explain why:			
Follow-up Meeting:			
If possible, would you like to schedu psychiatrist and your therapist to dis	-	Yes	No
Signatures:			
Patient Name:	Patient Signature:		
Witness Name:	Witness Signature:		
Date Completed:(YYYY-MM-DD)			
(1111-			