



STATEMENT OF DISAGREEMENT WITH A CLINICAL RECORD

This form is to be completed by the person who is in disagreement with the facts stated in their clinical record. It is to be attached to the person's clinical record.

Copies of this form must be provided to the:

- checkbox Chief Executive Officer, Whitehorse General Hospital; and
checkbox physician; and
checkbox anyone who has received copies of the clinical record in the past year.

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 file are incorrect (specify incorrect portions)

Multiple horizontal lines for specifying incorrect portions of the clinical file.

My opinion is that the correct facts are as follows

Multiple horizontal lines for stating correct facts.

DATED at _____,
this ____ day of _____, 20 ____.

Signature of applicant

Printed name of applicant