Santé et Services sociaux Québec

DT9193

# COMPLAINT
## Québec Electronic Health Record (QHR)

***Fields marked by an asterisk (*) must be completed.***

## Section A: PATIENT IDENTIFICATION

| | | | |
|---|---|---|---|
| * **RAMQ Health Insurance Number** | | * First name | * Last name |
| * Date of birth (Year / Month / Day) | * Gender ☐ F ☐ M | * Address | |
| * City | | * Province | * Postal code |
| * Area code * Principal phone | Area code Other phone | Email address | |
| * Mother's first name | * Mother's maiden name | * Father's first name | * Father's last name |
| Patient's attending physician | Area code Phone | Clinic/Attending physician's address | |

## Section B: IDENTIFICATION OF LEGAL REPRESENTATIVE

**Complete this section only if you are filing a request on behalf of the patient named in Section A.**

| | | | |
|---|---|---|---|
| First name | Last name | Area code Telephone | Relationship to the patient |
| Address | City | Province | Postal code |
| Email address | ***Please attach an original written delegation of authority or a copy of the document proving your status as a legal representative.*** | | |

## Section C: DETAILS OF THE COMPLAINT

**Please explain your complaint in detail:**

**Please state the objective of your complaint:**

## Section D: SIGNATURES

| | | |
|---|---|---|
| **Signature of the patient or legal representative** | | **Date** (Year / Month / Day) |
| ***Section reserved for the Medical Records Department for identification purposes*** | | |
| **Witness to the signature (optional)** | | **Date** (Year / Month / Day) |

Please return this form to the following address: **MSSS c/o Responsable DSQ de la coordination des plaintes, 405, avenue Ogilvy, 4e étage, Montréal (Québec) H3N 1M3**. For help completing this form, please contact : Régie de l'assurance maladie du Québec : (Québec) 418 646-4636 - (Montréal) 514 864-3411 - (Elsewhere in Québec) 1 800 561-9749
Access to information requests are processed in accordance with the legislation in effect at the time that request is filed.

# GUIDE FOR COMPLETING THIS FORM

### General use

Use this form to file a written complaint regarding the QHR. If you wish to file your complaint verbally, please call the RAMQ at the telephone number indicated on the reverse of this form and ask to register your complaint. A staff member will return your call.

## Section A: PATIENT IDENTIFICATION

■ **This section identifies the person filing the complaint. Fields marked by an asterisk (*) must be completed.**

**RAMQ Health Insurance Number, first name, last name, date of birth, and gender:** as they appear on the health insurance card.
**Address, city, province, and postal code:** address where correspondence is to be sent.
**Home phone, other phone, email address**: requested so that staff may contact the patient regarding this access to information request.
**Mother's first and maiden names, father's first and last names:** as they appear on the parties' birth certificate.
**Attending physician, telephone and address:** contact information of the attending physician or family doctor.

## Section B: IDENTIFICATION OF LEGAL REPRESENTATIVE

**If the person requesting that the information be corrected (the claimant) is not the patient, this section identifies that person. Only complete this section if you are making a request on behalf of the patient identified in section A. All fields marked with an asterisk (*) must be completed. You must also attach an original document, written by the patient, appointing you as his/her legal representative, or a copy of a document authorizing you to act as the patient's legal representative.**

**First and last name of the legal representative** as they appear on the legal representative's birth certificate (for identification purposes).
**Legal representative's telephone, address, city, province, postal code** so that staff may contact the legal representative regarding the request.
**Relationship to the patient:** State your relationship to the patient identified in section A. Examples of relationships: parental authority, legal representative, heir, director of professional services, complaints commissioner, private or public curator, party named in a court order.

## Section C: DETAILS OF THE COMPLAINT

■ **This section allows you to provide details regarding your complaint.**

In your own words, please specify any relevant information such as dates, places, professionals, and circumstances. You may add pages to this form if necessary.

## Section D: SIGNATURES

Please sign and date your complaint. A health records administrator may witness and sign your request after having confirmed your identity.

## Section reserved for the QHR representative to coordinate handling of the complaint

| Name (please print) | Signature | Date (year, month, day) |
|---|---|---|
| | | |