



Complaint Form *Personal Health Information Act*

This form is provided to allow you to provide all information related to your complaint. You may also send a letter outlining your complaint to the *Personal Health Information Act* contact person for the IWK Health Centre ("IWK") (see below for contact information).

1. PATIENT NAME AND CONTACT INFORMATION *(please print clearly)*

Last Name First Name Middle initial

Date of Birth (DD/MM/YYYY) IWK Unit Number (K#) if available

Mailing address

Daytime telephone number E-mail address *(only required if you wish to be contacted by e-mail)*

How do you wish to be contacted? Please check one: ☐ Phone ☐ Regular mail ☐ E-mail

If you are making the complaint on behalf of someone else, please provide your name and contact information:

Last Name First Name Middle initial

Relationship to patient

Mailing address

Daytime telephone number E-mail address *(only required if you wish to be contacted by e-mail)*

How do you wish to be contacted? Please check one: ☐ Phone ☐ Regular mail ☐ E-mail

You must attach a copy of the document authorizing you to make the complaint on behalf of the patient.
(Example: written consent of the individual, guardianship documents, declaration of Substitute Decision Maker form.)

2. DETAILS OF THE COMPLAINT

Please provide as much information as you can about the complaint you are making. Include details of the incident(s) leading to your complaint, the name of any individuals who are involved in the incident(s), the date when the incident(s) occurred, and any information about your efforts to attempt to resolve this complaint outside of this complaint process (e.g. informal discussions with someone involved in the incident). **Please attach any documents relevant to the complaint**



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3. RESOLVING THE COMPLAINT

What do you think should happen to resolve your complaint?

4. CONSENT AND SIGNATURE

To fully investigate your complaint, we may need to review your personal health information relevant to your complaint.

Please check and initial as you agree.

- ☐ _____ I consent to the IWK reviewing my personal health information in order to fully investigate my complaint; or
- ☐ _____ I **do not** consent to the IWK reviewing my personal health information in order to fully investigate my complaint

We may also need to discuss the facts presented on this form and any other information related to the complaint with individuals in our organization. **In this situation we will disclose only information relevant to the complaint. Please check and initial as you agree.**

- ☐ _____ I consent to the IWK Health Centre discussing the facts presented on this form and any other information related to the complaint with individuals in IWK. I understand that the IWK will only disclose information relevant to my complaint; or
- ☐ _____ I **do not** consent to the IWK discussing the facts presented on this form and any other information related to the complaint with individuals in the IWK.

Please note that we may not be able to fully investigate your complaint if we do not have access to all the relevant information related to your complaint.

Signature

Date

Please deliver or mail your original form to:

IWK Health Centre
Attention: Privacy Office
5850/5980 University Avenue
P.O. Box 9700
Halifax, NS B3K 6R8
Email: privacy@iwk.nshealth.ca

Phone: 902-470-6309 (local)
1-855-678-9811 (toll free)
Fax: 902-470-6651

If you have any questions about this form or the process for making a complaint, please contact the office noted above.