ALBERTA

OFFICE OF THE INFORMATION AND PRIVACY COMMISSIONER

ORDER H2007-006

November 12, 2007

CALGARY HEALTH REGION

Case File Number H0178

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Summary: Family history was provided for a psychiatric assessment of the Applicant's daughter at Alberta Children's Hospital ("ACH"), which included information about the Applicant and other family members. The Applicant alleges that the information about herself in her daughter's hospital record at ACH is her own health information and that Calgary Health Region (the "Custodian") improperly refused to correct or amend health information in contravention of section 13 of the *Health Information Act*, R.S.A. 2000, c. H-5 ("HIA").

The Adjudicator found that the information in the ACH Records was about a "health service" provided to the Applicant's daughter under section 1(1)(m)(i) and was the Applicant's daughter's "diagnostic, treatment and care information" under sections 1(1)(i)(i) and 1(1)(i)(ii) of HIA. Therefore, the information in the ACH Records was the Applicant's daughter's "health information" under section 1(1)(k)(i) of HIA. She found that the Applicant made a *request* for correction or amendment, but the requests did not pertain to the Applicant's *own health information*.

The Adjudicator found that the Applicant had no "health information" in the ACH Records, so there was no information to correct or amend under section 13 of HIA. Therefore, she confirmed the Custodian's decision not to correct or amend the information under section 13 of HIA. The Inquiry was held concurrently with an inquiry for Case File Review Number F4112 under section 36 of the *Freedom of Information and Protection of Privacy Act*, R.S.A. 2000, c. F-25 ("FOIP"), which resulted in Order F2007-027 and involved CHR and the same Applicant.

Authorities Cited: Ruth Sullivan, *Sullivan and Driedger on the Construction of Statutes*, 4th ed., Markham Ontario: Butterworths, 2002.

Orders Cited: AB: Orders F2007-027, H2006-003, H2005-007, H2005-006, F2005-017 & H2005-001, H2004-004, H2004-002, F2004-005 & H2004-001.

Statutes Cited: AB: *Health Information Act*, R.S.A. 2000, c. H-5, ss. 1(1)(i), 1(1)(i)(i), 1(1)(i)(ii), 1(1)(k), 1(1)(k)(i), 1(1)(m), 1(1)(m)(i), 1(1)(m)(i)(C), 1(2), 2(a), 2(b), 2(e), 2(f), 2(g), 11(1)(a), 11(1)(b), 11(2)(a), 13, 13(1), 14 and 80(3)(d); *Freedom of Information and Protection of Privacy Act*, R.S.A. 2000, c. F-25, s. 36; *The Personal Health Information Act,* S.M. 1997, c. P33.5, s. 1(1); *The Health Information Protection Act*, S.S. 1999, c. H-0.021) s. 2(m); *The Personal Health Information Act*, S.O. 2004, c. 3, Schedule A, ss. 4(1) and 4(3).

I. BACKGROUND

[para 1] Family history was provided for the psychiatric assessment of the Applicant's daughter at Alberta Children's Hospital ("ACH"), which included information about the Applicant and other family members. The Applicant alleges that the information about herself in her daughter's hospital record at ACH is her own health information and that Calgary Health Region ("CHR" or the "Custodian") improperly refused to correct or amend the health information in contravention of section 13 of the *Health Information Act*, R.S.A. 2000, c. H-5 ("HIA").

[para 2] The matters before the Inquiry arise in the context of multiple requests for access and correction or amendment made by the Applicant to CHR, which pertain to the Applicant's health information as well as her daughter's health information. As the matters were not resolved by mediation, Case File Review Numbers 3353, H0307 and H0178 were set down for inquiry. The Applicant asked that Case File Review Number H0178 (errors or omissions) be put into abeyance until the inquiries were concluded for Case File Review Numbers 3353 and H0307 (access request issues), which was granted.

[para 3] The previous inquiry resulted in Orders F2005-017 & H2005-001, where the Commissioner found that the Applicant did not have authority to exercise her mature minor daughter's rights or powers under section 104(1) of HIA. Therefore, the Commissioner did not have jurisdiction to decide issues about the Applicant's requests pertaining to access to her daughter's health information. The background facts already provided in the previous Orders will not be repeated in this Order.

[para 4] A written inquiry for the issues remaining under Case File Review Number H0178 was reconvened under HIA (the "Inquiry"). On March 5, 2007, the Information and Privacy Commissioner, Frank Work (the "Commissioner"), delegated me to hear the Inquiry. The Applicant made a request for extension, which was granted. Later, CHR made a request for extension as well as a request for change in the inquiry process, in particular, for change in the submission exchange process.

[para 5] CHR's request for extension was denied. However, CHR's request for change in the inquiry process was partially granted. The Applicant was required to

provide the records at issue at the Inquiry. Additionally, the parties were granted additional time to prepare rebuttal submissions after initial submissions were exchanged, due to the unique circumstances of this case.

[para 6] At the Inquiry, the parties provided written initial and written rebuttal submissions that were exchanged between the parties. In its written initial submission, CHR provided the Affidavit of its Access and Privacy Coordinator that contains the further Affidavit of a former CHR employee who was involved in responding to the Applicant's requests. In its rebuttal submission, CHR provided the further Affidavit of an ACH psychiatrist who was involved in providing health services to the Applicant's daughter. In her written initial submission, the Applicant provided the records at issue.

[para 7] When the Inquiry was being reconvened, an issue arose about application of section 36 of the *Freedom of Information and Protection of Privacy Act*, R.S.A. 2000, c. F-25 ("FOIP"). Therefore, the Inquiry was held concurrently with an inquiry for Case File Review Number F4112 under FOIP, which resulted in Order F2007-027. CHR and the Applicant provided the same written submissions for both inquiries.

II. RECORDS AT ISSUE

[para 8] The Applicant's initial written submission contains the records that it appears the Applicant regards as being at issue, intermingled with the Applicant's representations of facts, argument and evidence. The Applicant does not provide a copy of the records at issue under separate cover or explicitly identify the particular records that the Applicant says are at issue.

[para 9] The Applicant's initial written submission begins with a description of alleged errors and omissions in her own health information. The Applicant's initial written submission includes an "Appendix" with a list of 36 attachments, which the Applicant provides under numbered tabs. The Applicant refers to each attachment as a separate appendix. For clarity, this Order refers to the attachments to the Appendix as "Tabs".

[para 10] This Order adopts the Applicant's numbering system and describes the Tabs as follows:

- Tab 1: Letter from Applicant to CHR, October 14, 2002 (20 pages),
- Tab 2: Letter from Applicant to CHR, October 28, 2002 (6 pages),
- Tab 3: Letter to Applicant from CHR, December 20, 2002 (2 pages),
- Tab 4: ACH Psychiatrist Outpatient Contact Note, June 14, 2000 (2 severed pages),
- Tab 5: ACH Psychiatrist Report, June 20, 2000 (3 severed pages),
- Tab 6: ACH Mental Health Program Family Information Sheet (1 page),
- Tab 7: Letter to ACH from Bowmont Medical Clinic, March 20, 2000 (1 severed page),
- Tab 8: ACH Social Work Genogram, undated (1 severed page),
- Tab 9: Police Report pertaining to July 13, 2000 (1 severed page),

- Tab 10: Police Contact Notes to Child Welfare Services, July 30, 2000 (1 severed page),
- Tab 11: Letter copied to Applicant from Rockyview Child & Family Services Social Worker, November 16, 2000 (1 page),
- Tab 12: Letter from Turnbull Grobman, November 5, 2001 (3 pages),
- Tab 13: Notice of Motion & Affidavit, October 5, 2001 (8 pages),
- Tab 14: Letter from College of Alberta Psychologists, August 14, 2003 (1 page),
- Tab 15: Letters from Turnbull Grobman, January 31, 2002 and December 12, 2001 (4 pages),
- Tab 16: ACH Psychologist Report, August 17, 2001 (10 severed pages),
- Tab 17: ACH Psychologist Letter to Applicant, August 1, 2002 (3 pages),
- Tab 18: CHR Psychologist Letter to Applicant, June 30, 2000 (1 page),
- Tab 19: ACH Social Work Outpatient Contact Note, July 17 and 18, 2000 (1 severed page),
- Tab 20: Child Welfare Services Contact Notes, September 10, 2001 (1 severed page),
- Tab 21: Article about Lupus and Prednisone (1 page),
- Tab 22: Article about Prednisone and Depression (6 pages),
- Tab 23: Article about Lupus and Corticosteroids (6 pages),
- Tab 24: Physician Reports (total of 7 pages):
    - University of Calgary Medical Clinic Physician Reports:
        - June 7, 2002 (rheumatologist) (2 pages), and
        - March 5, 2001 (rheumatologist) (first 3 pages of report), and
    - CHR Foothills Medical Centre Consultation Report, June 24, 2005 (neurologist) (2 pages),
- Tab 25: Articles about Lupus and Vasculitis (5 pages),
- Tab 26: Article about Lupus and Stress (2 pages),
- Tab 27: Child Welfare Services Contact Notes, May 30, 2001 (1 severed page),
- Tab 28: ACH Psychiatrist Report, July 24, 2000 (4 severed pages),
- Tab 29: Physician Report, December 20, 2001 (specialist in psychiatry) (2 pages),
- Tab 30: Letter from Applicant's Ex-Husband, July 1, 2007 (1 page),
- Tab 31: Information about Lupus and Psychotic Disorders (1 page),
- Tab 32: Information about Lupus (13 pages),
- Tab 33: ACH Psychologist Report, August 17, 2001 (1 severed page; duplicate of page two in Tab 16),
- Tab 34: Letter from Applicant to Ex-Husband, July 18, 2000 (1 page),
- Tab 35: Divorce Judgement and Corollary Relief Order, January 12, 2000 (2 pages), and
- Tab 36: ACH Psychiatrist Outpatient Contact Note, August 24, 2000 (1 page).

[para 11] In order to dispose of the issues at the Inquiry, this Order divides the Applicant's initial written submission into categories, as follows.

[para 12] *Description of Alleged Errors and Omissions* - The Applicant's written initial submission has a 56-page overview pertaining to alleged errors and omissions. The 56 pages contain 14 numbered points summarizing corrections and amendments requested for the alleged errors and omissions. The 56 pages refer throughout to the Applicant's previous descriptions of alleged errors and omissions in two October letters provided in

Tab 1 and Tab 2. Therefore, the Applicant describes the alleged errors and omissions in her own health information in the following 82 single spaced pages:

- Written initial submission (56 pages),
- Tab 1: Letter from Applicant to CHR, October 14, 2002 (20 pages), and
- Tab 2: Letter from Applicant to CHR, October 28, 2002 (6 pages).

[para 13] *Records At Issue (ACH Records)* - The Applicant's 14 points of corrections and amendments for the alleged errors and omissions in her own health information pertain to the following five Tabs. The Applicant requests correction or amendment to this information. Therefore, I am regarding the following five Tabs, consisting of 20 severed pages, as the records at issue at the Inquiry:

- Tab 4: ACH Psychiatrist Outpatient Contact Note, June 14, 2000 (2 severed pages),
- Tab 5: ACH Psychiatrist Report, June 20, 2000 (3 severed pages),
- Tab 8: ACH Social Work Genogram, undated (1 severed page),
- Tab 16: ACH Psychologist Report, August 17, 2001 (10 severed pages), and
- Tab 28: ACH Psychiatrist Report, July 24, 2000 (4 severed pages).

[para 14] For brevity, I will collectively refer to Tabs 4, 5, 8, 16 and 28 as the records at issue, and in particular, as the Alberta Children's Hospital Records ("ACH Records"). All of the ACH Records are written on ACH letterhead. The top right hand corner of each of the ACH Records contains the Applicant's daughter's name, date of birth, ACH registration number or HRN (hospital registration number), ACH chart number and/or Alberta Health Care Insurance Number.

[para 15] *Information Pertaining to Alleged Omissions About Lupus* – The Applicant does *not* request correction or amendment to this information. The Applicant provides the following seven Tabs, consisting of 34 pages, in support of the position that there are omissions pertaining to the medical condition of Lupus in her own health information in the ACH Records:

- Tab 21: Article about Lupus and Prednisone (1 page),
- Tab 22: Article about Prednisone and Depression (6 pages),
- Tab 23: Article about Lupus and Corticosteroids (6 pages),
- Tab 25: Articles about Lupus and Vasculitis (5 pages),
- Tab 26: Article about Lupus and Stress (2 pages),
- Tab 31: Information about Lupus and Psychotic Disorders (1 page), and
- Tab 32: Information about Lupus (13 pages).

[para 16] *Information Pertaining to Other Alleged Errors and Omissions* - The Applicant does *not* request correction or amendment to this information. The Applicant provides the following 14 Tabs, consisting of 30 pages, in support of the position that there are errors and omissions in her own health information in the ACH Records:

- Tab 3: Letter to Applicant from CHR, December 20, 2002 (2 pages),
- Tab 9: Police Report pertaining to July 13, 2000 (1 severed page),

- Tab 10: Police Contact Notes to Child Welfare Services, July 30, 2000 (1 page),
- Tab 11: Letter copied to Applicant from Rockyview Child & Family Services Social Worker, November 16, 2000 (1 severed page),
- Tab 12: Letter from Turnbull Grobman, November 5, 2001 (3 pages),
- Tab 13: Notice of Motion & Affidavit, October 5, 2001 (8 pages),
- Tab 14: Letter from College of Alberta Psychologists, August 14, 2003 (1 page),
- Tab 15: Letters from Turnbull Grobman, January 31, 2002 and December 12, 2001 (4 pages),
- Tab 17: ACH Psychologist Letter to Applicant, August 1, 2002 (3 pages),
- Tab 20: Child Welfare Services Contact Notes, September 10, 2001 (1 severed page),
- Tab 27: Child Welfare Services Contact Notes, May 30, 2001 (1 severed page),
- Tab 30: Letter from Applicant's Ex-Husband, July 1, 2007 (1 page),
- Tab 34: Letter from Applicant to Ex-Husband, July 18, 2000 (1 page), and
- Tab 35: Divorce Judgement and Corollary Relief Order, January 12, 2000 (2 pages).

[para 17] *Records Designated With Applicant's Daughter's Identifying Information* - The Applicant does *not* request correction or amendment to this information. Each Tab contains the Applicant's daughter's name, telephone number, home address, hospital registration number, gender, age, date of birth and/or personal health number. Each Tab is on ACH letterhead except Tab 7, which is a physician referral to ACH. The Applicant provides the following six Tabs, consisting of six severed pages, in support of the position that there are errors and omissions in her own health information in the ACH Records:

- Tab 6: ACH Mental Health Program Family Information Sheet (1 page),
- Tab 7: Letter to ACH from Bowmont Medical Clinic, March 20, 2000 (1 severed page),
- Tab 18: CHR Psychologist Letter to Applicant, June 30, 2000 (1 page),
- Tab 19: ACH Social Work Outpatient Contact Note, July 17 and 18, 2000 (1 severed page),
- Tab 33: ACH Psychologist Report, August 17, 2001 (1 severed page; duplicate of page two in Tab 16), and
- Tab 36: ACH Psychiatrist Outpatient Contact Note, August 24, 2000 (1 page).

[para 18] *Records Designated With Applicant's Identifying Information* - The Applicant does *not* request correction or amendment to this information. The first page of each Tab has a "Re:" line with the Applicant's name and sometimes with first name, nickname and last name. The headers on additional pages contain the Applicant's name. Some of the Tabs have the Applicant's DOB (date of birth), ID # (identification number) and AHC # (Alberta health care number). The Applicant provides the following two Tabs, consisting of four physician reports and seven pages, in support of the position that there are errors and omissions in her own health information in the ACH Records:

- Tab 24: Physician Reports (total of 7 pages):
    - University of Calgary Medical Clinic Physician Reports:
        - June 7, 2002 (rheumatologist) (2 pages), and
        - March 5, 2001 (rheumatologist) (first 3 pages of report), and

- CHR Foothills Medical Centre Consultation Report, June 24, 2005 (neurologist) (2 pages), and
- Tab 29: Physician Report, December 20, 2001 (specialist in psychiatry) (2 pages).

[para 19] In summary, the Applicant provides a total of 159 pages in support of the allegation that there are errors and omissions in her own health information, which consists of 82 pages of description and 77 pages in 28 Tabs. The alleged errors and omissions consist of 20 severed pages in the ACH Records.

III. ISSUES

[para 20] The issues in the Notice of Inquiry are:

- ISSUE A: Did the Applicant request correction or amendment of her own health information?

- ISSUE B: If the answer to Issue A is yes, is the health information of the Applicant to which the request pertains in the custody and control of the Custodian within the terms of section 13(1) of HIA?

- ISSUE C: If the answers to Issues A and B are yes, did the Custodian refuse to make the corrections or amendments to the Applicant's health information that she requested?

- ISSUE D: If the answer to Issue C is yes, was the Custodian's refusal to correct or amend the Applicant's health information authorized by section 13 of HIA?

[para 21] In this Order, the references to Questions 1 through 4 in the Notice of Inquiry are to be read as references to Issues A through D, respectively.

IV. PRELIMINARY ISSUES

Scope of Inquiry

[para 22] When the Commissioner was considering whether to reconvene the Inquiry for Case Review Number H0178, he sent the parties the following September 20, 2006 letter, which CHR provided at the Inquiry as Exhibit B of the Affidavit of its Access and Privacy Coordinator. This letter sets out the following limits to the scope of the Inquiry due to issues already decided in Orders F2005-017 & H2005-001:

> The result of Order F2005-017/H2005-001 is that [name of Applicant] cannot exercise rights over her daughter's health information under HIA. Therefore, in an inquiry for Review Number H0178, I will not be considering a correction request for records pertaining to [name of Applicant's daughter] health information when a health service was being provided to her daughter. I will only be considering a correction request for

> records pertaining to [name of Applicant] health information when a health service was being provided to [name of Applicant].

Records at Issue

[para 23] The September 20, 2006 letter requested the parties to provide the records at issue and the list of corrections, as follows:

> I now require that the Calgary Health Region and [name of Applicant] provide me with the records pertaining to [name of Applicant] health information when a health service was being provided to [name of Applicant]. I also require a list of the corrections requested for that health information.

[para 24] CHR responded to the request in a letter dated October 2, 2006, which it provided at the Inquiry as Exhibit C of the Affidavit of its Access and Privacy Coordinator. The relevant parts of CHR's letter are:

> Upon reviewing [name of Applicant's] requests, we have determined that she did not request any corrections to records pertaining to her health information that was generated when a health service was being provided directly to [name of Applicant].
>
> As [name of Applicant's] requests do not relate to any records generated when health services were provided directly to [name of Applicant], we do not have any records that are responsive to your request.

[para 25] The Applicant disagreed with the position taken by CHR. The Applicant says that CHR has records that contain her own health information, rather than just her daughter's health information, and that there are errors and omissions in her own health information in CHR records.

Production of Records

[para 26] During the Inquiry, the issue arose as to which party is required to provide the records at issue at the Inquiry. The Notice of Inquiry states:

> <u>Records At Issue</u>
> The Public Body/Custodian must supply one copy of the records at issue (under separate cover) to the Commissioner with its initial brief.

[para 27] CHR wrote a letter to the Office dated June 26, 2007, saying that it could not comply with the above requirement for CHR to provide records as in the Notice of Inquiry, as previously stated in its October 2, 2006 letter. CHR reiterated its position, that there are no records at issue because in its view the information the Applicant alleges is at issue is health information about the Applicant's daughter and not health information about the Applicant.

[para 28] The Notice of Inquiry also states:

Issues in the Inquiry

Without limiting the Commissioner, the issues in this inquiry are:

1. Did the Applicant request correction and amendment of her own health information?

The answer to this question will require the Applicant to identify the specific parts of her correspondence with the Custodian that allege errors and omissions in her own health information and request it to be corrected or amended.

It will also require the Commissioner to determine whether that information was health information of the Applicant, as the term "health information" is defined under section 1(1)(k) of the Health Information Act ("HIA"). Both the Applicant and the Custodian should make submissions on this question. …

3. If the answers to questions 1 and 2 are yes, did the Custodian refuse to make the corrections and amendments to the Applicant's health information that she requested?

Both parties should provide submissions on this question, with any supporting documentation, and should identify specifically which words or information constitutes the refusal to correct or amend.

[para 29] The Office replied to CHR in a letter dated July 3, 2007 that is copied to the Applicant, which says:

> You are correct that the Notice of Inquiry says that the Public Body/Custodian must supply a copy of the records at issue with its initial brief. This is a standard provision in our Notices that does not apply in this case. I confirm that due to the unique circumstances in this case, we are not asking or requiring the Public Body/Custodian to supply a copy of the records at issue. We understand that it is not possible for the Public Body/Custodian to provide the records at issue with its initial brief. I also confirm that in this case, the Applicant is required to supply the copy of the records at issue with her initial brief. In particular, as set out in #1 of the Notice of Inquiry, in her initial brief the Applicant is required to identify the specific parts of her correspondence with CHR that allege errors and omissions in her own health information and that describe her request to CHR for her health information to be corrected or amended. As set out in #3 [sic] of the Notice of Inquiry, in her initial brief the Applicant is required to specifically identify which words in her health information is [sic] to be corrected or amended in the records at issue.

[para 30] The usual process for production of records at an HIA inquiry is set out in the Notice of Inquiry to the parties, which is that the custodian must provide a copy of the records at issue under separate cover in its initial submission. However in this situation, CHR has consistently said that in its view there are no records at issue, so it is unable to provide any such records. I accept CHR's representations that in the unique circumstances of this case it is unable to provide the records at issue at the Inquiry.

[para 31] It is the Applicant who takes the position that there *are* records at issue that pertain to her own health information when a health service was being provided to the Applicant. Therefore in this case, as stated in the letter of July 3, 2007, the Applicant is required to provide the records at issue at the Inquiry. Also as stated in the Notice of Inquiry, the records at issue are the records pertaining to the Applicant's own health information when a health service is being provided to the Applicant.

Non-Inquiry Issues

[para 32] In her written submissions, the Applicant raises a number of matters that fall outside the correction or amendment issues that are the subject of the Inquiry. For example, there are references to child welfare, law enforcement, criminal justice and the legal system as well as to quality of care complaints pertaining to CHR, ACH and health services providers. My jurisdiction at the Inquiry and the scope of this Order are restricted to the correction or amendment issues raised by the Applicant in any requests made to CHR for correction or amendment of her own health information under HIA.

[para 33] In particular, the Inquiry pertains to the Applicant's letters dated October 14, 2002 (20 pages) and October 28, 2002 (6 pages). I do not have jurisdiction at the Inquiry to make decisions about other issues raised by the Applicant that go beyond the correction or amendment issues before me under section 13 of HIA. Section 80(3)(d) of HIA allows me to confirm a decision not to correct or amend health information or to specify how health information is to be corrected or amended. My authority in this case is restricted to reviewing CHR's decision not to correct or amend the Applicant's own health information under section 13 of HIA.

Burden of Proof

[para 34] HIA is silent about the burden of proof for correction and amendment issues under section 13. Orders previously issued under HIA say that where HIA is silent, the burden of proof must be decided on a case-by-case basis. Where HIA is silent, the party that is in the best position to address the matter at issue usually has the burden of proof (Orders: H2006-003, paras 7-11; H2005-007, paras 53, 66-67; H2005-006, paras 42, 45-46, 72-73; H2004-004, paras 12, 21).

[para 35] Previous Orders issued under section 13(1) of HIA say that an applicant is usually in the best position to show where there is an error or omission in that person's own health information (Orders: H2005-007, paras 53, 66-67; H2005-006, paras 42, 72-73; H2004-004, para 12). Previous Orders issued under the balance of section 13 of HIA say that a custodian who refuses to correct or amend is usually in the best position to speak to the reasons for refusal (Orders: H2005-007, para 53; H2005-006, paras 42, 45-46; H2004-004, para 21).

[para 36] In the circumstances of this case, I find that the Applicant is in the best position to show that she made a request for correction or amendment, that the request

pertains to the Applicant's own health information and that there are errors or omissions in the Applicant's own health information. Therefore, I find that the Applicant has the initial burden of proof for these issues. If the Applicant discharges this initial burden, then the burden of proof shifts to CHR who is in the best position to justify its refusal to correct or amend the Applicant's own health information.

V. DISCUSSION OF INQUIRY ISSUES

ISSUE A: DID THE APPLICANT REQUEST CORRECTION OR AMENDMENT OF HER OWN HEALTH INFORMATION?

[para 37] I will consider Issue A in two parts, as follows:

1. Did the Applicant make a *request* for correction or amendment? If the answer to the first part of Issue A is "yes", I will go on to consider the second part of Issue A.

2. Did the Applicant's request pertain to the Applicant's *own health information*? If the answer to the second part of Issue A is also "yes", then the answer to all of Issue A is "yes".

[para 38] If the answer to Issue A is "yes", I will go on to consider the other issues at the Inquiry. However, Issue A is a threshold issue. If the answer to either of the parts in Issue A is "no", then the answer to all of Issue A is "no". If the answer to all of Issue A is "no", there are no issues to consider under Issue B, Issue C or Issue D.

1. Did the Applicant make a request for correction or amendment?

General

[para 39] Section 13(1) of HIA reads:

> 13(1) An individual who believes there is an error or omission in the individual's health information may in writing request the custodian that has the information in its custody or under its control to correct or amend the information.

Facts, Evidence and Argument

Applicant

[para 40] The Applicant's written initial submission comments about the Applicant's correspondence with CHR:

> In reviewing my correspondence with the Calgary Health Region, two things become evident. The first thing is that my correspondence was not at all concise, was long

> winded, verbose and overly detailed. I apologize to the Health Region and to the Information and Privacy Commissioner for not being more clear and concise in my correspondence. I ask that it be noted that at that time, I was very ill with a condition called Systemic Lupus …
>
> I now realize the "legalistic" requirements for requesting information to be changed and the great need for specificity. My correspondence to the Calgary Health Region in October of 2002, was written under the belief that errors and omissions had occurred in the record and that if I reported the missing and relevant information, the Calgary Health Region, would in the interest of accuracy, willingly correct the errors.

[para 41] The Applicant's written initial submission comments about an October 14, 2002 letter that the Applicant sent to CHR. The Applicant says:

> In my letter dated October 14, 2002, to [name of individual] of the Calgary Health Region, (appendix #1), I outlined many of the inaccuracies and omissions made in the reports written by Children's Hospital and I gave my own narration of what I believed had actually been said and done at my attendances at Children's Hospital in the year 2000. I did not specifically make a request for individual corrections to be made but after indentifying all the inaccuracies, I did ask on Page 19, what the Children's Hospital intended to do to remedy the erroneous information. … It was my belief at the time, that so many of the reports were riddled with errors and omissions, that a major overhaul was required, as opposed to correcting just a few specific sentences.

[para 42] The Applicant provides a copy of the October 14, 2002 letter under Tab 1, which is a 20-page single spaced letter. The Applicant asks CHR to do a number of things, including the following:

> I would like to know how Children's Hospital intends to remedy the erroneous information that they put on file about me.

[para 43] The Applicant's written initial submission comments about an October 28, 2002 letter that the Applicant sent to CHR. The Applicant provides a copy of this letter, which is a 6-page single spaced letter, under Tab 2. The Applicant says:

> On October 28, 2002, I wrote another letter to [name of individual], (appendix #2), and added some additional errors and omissions that I had not noted in my first letter. … I did not itemize specific corrections I wanted to be made. Instead, I just reported my version of events and assumed that with the facts now in hand, some effort would be made to adjust the records to reflect events more accurately.

[para 44] The Applicant's written initial submission comments about a letter that the Applicant sent to the Office that is dated January 2, 2003. This letter is the Applicant's request for review of CHR's response to the Applicant. The Applicant says:

> In that letter, I itemized the errors and omissions I wanted corrected and apparently, I added some that I had not previously specified to the Calgary Health Region. … I began to understand that I could not ask for information regarding my daughter to be changed, and that I could only ask for information pertaining to my own HEALTH information to be changed.

[para 45] The Applicant says she made requests for correction or amendment to CHR. The Applicant says that CHR responded to the two above described October letters under HIA and agreed to make corrections, and that this means she made a request for correction or amendment. The Applicant says the wording in CHR's December letter of response shows that CHR interpreted the Applicant's two October letters as requests for correction or amendment, so this means that she made requests for correction or amendment.

Custodian

[para 46] In its written initial and written rebuttal submissions CHR says that the answer to Inquiry Issue A is "no". Therefore, in CHR's view, the Applicant did not request correction or amendment of her own health information. However, CHR did not specifically comment in its written submissions about whether, in its view, the Applicant made a *request* for correction or amendment.

[para 47] In its initial written submission, CHR provided its letter of response to the Applicant's two October letters, which is dated December 20, 2002. CHR provided this letter in Exhibit 7 of the Affidavit of its former employee. The Applicant also provided this letter in Tab 3 of the written initial submission and as an attachment to the written rebuttal submission. CHR's letter says:

> **Re: Your request for your correction of personal health information under the Health Information Act**
>
> Some of the information you requested corrected or amended has been agreed to by the Calgary Health Region. …
>
> A copy of the amended record will follow.
>
> All other requests for correction or amendment have been refused by the Calgary Health Region, you may either:
>
> > (a) Ask for a review of this decision by the Information and Privacy Commissioner under section 73 of the Act;
> >
> > or
> >
> > (b) Submit within 30 days of receiving this notice a statement of disagreement to the Calgary Health Region setting out in 500 words or less the requested correction or amendment and your reasons for disagreeing with the decision.
>
> Your statement of disagreement will be attached to the record that is the subject of the requested correction or amendment and will be provided to any person to whom the Calgary Health Region has disclosed the record in the year prior to the request.

Under section 73(1) of the *Health Information Act*, you may ask also the Information and Privacy Commissioner to review this decision.

Application

[para 48] Section 13(1) of HIA requires an individual who believes there is an error or omission in their own health information to make a written request for correction or amendment to the custodian that has the information in its custody or under its control. An applicant must make a request for correction or amendment of an error or omission in their own health information in order to trigger section 13 of HIA.

[para 49] In regard to the October 14, 2002 correspondence to CHR the Applicant says, "I did not specifically make a request for individual corrections to be made but after identifying all of the inaccuracies, I did ask on page 19, what the Children's Hospital intended to do to remedy the erroneous information." Nevertheless, the Applicant says that the various descriptions of errors and omissions were requests for correction or amendment to her own health information in the ACH Records.

[para 50] At the Inquiry, CHR does not dispute that the Applicant made requests for correction or amendment. When responding to the Applicant, CHR did not say that the Applicant's letters were not requests for correction or amendment. In fact, CHR's response to the Applicant in its December letter begins, "Re: Your request for correction of personal health information under the Health Information Act". CHR's December letter refers throughout to the Applicant's requests for correction or amendment.

[para 51] The Applicant says that the above sentence within the 26 single-spaced pages, was a request for correction or amendment. On the one hand, the Applicant's question to CHR as to what ACH intended to do about the erroneous information, is indirect and vague. An applicant making a request for correction or amendment must provide enough clarity to enable a custodian to respond to the request. On the other hand, the Applicant's question arose relatively early during the implementation of HIA when the details of HIA were not well understood.

[para 52] In my view, an applicant's written description of errors and omissions is not the same thing as a written request for correction or amendment under section 13(1) of HIA. A custodian's response to a written description of errors and omissions, even where the response agrees to make or refuses to make certain corrections, does not necessarily mean that an applicant has made a request for correction or amendment under HIA. The custodian's response is not determinative, but is a factor to consider.

[para 53] CHR could have taken the position with the Applicant that there is no request for correction or amendment under HIA. However, to CHR's credit, CHR did not take that approach. CHR gave the Applicant the benefit of the doubt and responded to the Applicant under HIA. CHR agreed to make certain corrections and refused to make further corrections to the ACH Records. CHR advised the Applicant of options under section 14 of HIA when a custodian refuses to make a correction or amendment,

which is to submit a statement of disagreement or to ask the Commissioner to review the decision. The Applicant chose the latter option.

[para 54] The above factors weigh in favour of a finding that the Applicant made a request to CHR for correction or amendment. In the particular circumstances of this case, I accept the submission of the Applicant that there is a request for correction or amendment. However, I only accept the Applicant's submission insofar as it pertains to the Applicant's two above described letters of October 14th and 28th. The Inquiry is a *review* of a decision not to correct or amend the Applicant's health information. The only decision before me to review is CHR's decision that is described in its December 20, 2002 letter.

[para 55] For all of the above reasons, I find that the Applicant discharged the burden of proof to show that there was a *request* for correction or amendment of alleged errors or omissions in the ACH Records. This means that the answer to the first part of Issue A is "yes", in that I find that the Applicant made a *request* for correction or amendment.

2. Did the Applicant's request pertain to the Applicant's own health information?

[para 56] I will consider the second part of Issue A under the following questions:

- Must there be a "health service" for "diagnostic, treatment and care information" under HIA?
- Does family history fall within the definition of "health information" under HIA?
- Is the Family History the Applicant's *own health information* under HIA?

General

[para 57] The provisions that are relevant to the definition of "health information" under HIA in the circumstances of this case, are:

> 1(1)(i) "diagnostic, treatment and care information" means information about any of the following:
>
> (i) the physical and mental health of an individual;
>
> (ii) a health service provided to an individual; …
>
> and includes any other information about an individual that is collected when a health service is provided to the individual, but does not include information that is not written, photographed, recorded or stored in some manner in a record.
>
> 1(1)(k) "health information" means any or all of the following:
>
> (i) diagnostic, treatment and care information.

1(1)(m) "health service" means a service that is provided to an individual

(i) for any of the following purposes and is directly or indirectly and fully or partially paid for by the Department: …

(C) diagnosing and treating illness.

Facts, Evidence and Argument

Applicant

Argument

[para 58] The Applicant's initial written submission says that the information containing the alleged errors and omissions in the ACH Records is her own health information, as follows:

> I have had to reduce my original requests for corrections to be made, to only those that I believe deal with my own health information. … Although my request for corrections will be limited to information made when a health service was being provided to me personally during my attendances at the Children's Hospital, the information created about me was not put on a health record individually identified by my own name and health number.

[para 59] The Applicant's written rebuttal submission asks:

> If my personal health information was not deemed to have been recorded that day, who's [sic] information was it? If my health information was not relevant to the file and [name of Applicant's daughter's] information was not involved, why record it at all?

[para 60] Due to the extent of the allegations, this Order cannot describe every instance where the Applicant says there are errors or omissions in her own health information in the ACH Records. In fact, the Applicant says the ACH Records are "riddled with errors and omissions" and require a "major overhaul". This Order will provide examples of the Applicant's alleged errors and omissions to illustrate the type of information that the Applicant says is her own health information in the ACH Records.

Records at Issue (ACH Records)

[para 61] *Tab 4 (2 severed pages)* - This handwritten notation of an ACH psychiatrist is dated June 14, 2000. The notation is written on an "Outpatient Contact Note" and is entitled" Psychiatry". The same psychiatrist made the typewritten report in Tab 5. Tab 4, in its entirety, states:

> During the team evaluation of [name of Applicant's daughter] and her family involving myself, [names of health services providers] and [name of Applicant's daughter's] mother, [name of Applicant], appeared to become upset with the recommendation which

> was made for family therapy. [Name of Applicant] requested that the rest of the family leave the room, and began to express concerns regarding the family situation.
>
> [Name of Applicant] became tearful, emotionally labile and expressed feelings of suicidality [sic]. She also reported feeling unsure that she could continue in the current living situation and expressed that at times she has felt like harming [name of Applicant's daughter]. [Name of Applicant] reported feeling frustrated and overwhelmed. A plan was made that, given [name of Applicant's] presentation, an ER assessment at Foothills Hospital may need to take place.
>
> Over time, [name of Applicant] was able to de-escalate and discuss options for intervention. She was in agreement with the plan for [name of Applicant's daughter] to receive psychological testing through ACH. She reported feeling hopeless and frustrated as she has in the past and reported that she would never harm herself as she was too strong a person and had to caretake for her daughters. [Name of Applicant] was able to develop a safety plan to have her past therapist, [name of therapist] call to check in with her in a few hours at home. [Name of therapist] was contacted by phone, informed of the current concerns and was in agreement with the plan. If there were concerns during her phone call, she would have an ambulance sent to the home. She was also in agreement that [name of Applicant] requires additional support at this time, and stated that she would follow up with this.
>
> [Name of Applicant] reported that she was comfortable with the plan and that if concerns escalated at home regarding [name of Applicant's daughter's] safety, she would contact Wood's CRT. The family left the hospital in agreement with the plan for a psychological assessment of [name of Applicant's daughter], family therapy through the U of C Family Therapy Program, and Wood's CRT for crisis support.

[para 62] Points one to four of the 14 points in the Applicant's written initial submission summarize the corrections and amendments for the alleged errors or omissions in her own health information in Tab 4. For example, in regard to the above words, "became tearful, emotionally labile and expressed feelings of suicidality", the Applicant says:

> Dr. [name of psychiatrist] misinterpreted the real meaning of what I said, when she interpreted my statement to be one of suicidal intent. Clearly, when Dr. [name of psychiatrist] is discussing her opinion that I became emotionally labile, and suicidal, these are statements about my mental health and no one else's. The problem was that Dr. [name of psychiatrist] was so unfamiliar with me and my history, that she did not make a "professional opinion", she made an ill informed assumption. I was tearful and emotionally labile, but I did not express feelings of "suicidality." …
>
> While I understand that Dr. [name of psychiatrist] may be entitled to her view or opinion that I was emotionally labile or suicidal, I do not believe that she is entitled to fabricate information in place of fulfilling her professional duty. The rest of Dr. [name of psychiatrist's] "contact sheet" was full of misrepresentations and outright lies.

[para 63] As a further example, the Applicant alleges that the reference to a safety plan in Tab 4 is an error or omission in her own health information, as follows:

> I did not "develop a safety plan." As Dr. [name of psychiatrist] states in her notes. Why would I do that? I had already stated that I would never harm myself and that is in Dr. [name of psychiatrist's] notes. … This discussion about a safety plan was not about [name of Applicant's daughter], it was about me and their concerns about my mental health. As such, it was a health service that they attempted to deliver to me and I, therefore, request a correction to the record.

[para 64] *Tab 5 (3 severed pages*) - This typewritten report of an ACH psychiatrist pertains to a June 14, 2000 consultation that is entitled, "Psychiatric Assessment". This psychiatric assessment of the Applicant's daughter was conducted by a team at ACH that included the psychiatrist, a social worker and a psychologist. Tab 5 states:

> **History of Present Illness**: There have been significant stressors, including family conflict, parental separation two years ago, grandmother's death in January 2000, and mother's ongoing illness with lupus.
>
> **Family History**: [Name of Applicant] reports alcohol and substance abuse on her side of the family. She herself reports a history of depression, treated with therapy since the age of 11 years, and with an antidepressant in the past.

[para 65] Number five of the 14 points in the Applicant's written initial submission describes corrections and amendments that the Applicant requests for alleged errors and omissions in her own health information in Tab 5, as follows:

> I did not say this to Dr. [name of psychiatrist]. My history was not discussed with Dr. [name of psychiatrist] during the assessment that took place on June 14, 2000. The statements made about [name of Applicant's daughter] and myself were **not** given to Dr. [name of psychiatrist] on June 14, 2000. Neither [name of social worker] nor Dr. [name of psychiatrist] took any notes during that assessment. There are no notes on file (that I have been provided with), that document the contents of that interview.
>
> My childhood difficulties were never given to Dr. [name of psychiatrist] during the assessment because I was not asked about it. If I had been asked, I would probably have said little because my children were present and I had no desire for them to learn negative things about their grandparents or their uncles.
>
> When I uttered the statement that alarmed Dr. [name of psychiatrist] so much , she left the room immediately and when she returned, she insisted on having me retract my statement and then threatened to send me to Foothills Hospital for a psychiatric assessment to be done on me.
>
> The only time I recall discussing my personal mental history was when we met with the "Emergent Care Team" at Dr. [name of individual] request. That team consisted of the three social workers [names of social workers]. That meeting took place about one week after our initial meeting with Dr. [name of psychiatrist]. On that occasion, they did a "genogram" on the blackboard.

[para 66] *Tab 8 (1 severed page)* – The handwritten notations and diagrams in Tab 8 are entitled, "Genogram". This undated page is the Applicant's daughter's family tree, prepared by ACH social workers from information obtained from the Applicant. The

bottom of the page contains a legend with words, symbols and diagrams that include "identified patient", "family members living together" "married, separated and divorced" and "relationships: close, distant and conflictual".

[para 67] Number five of the 14 points in the Applicant's written initial submission describes corrections and amendments that the Applicant requests for alleged errors and omissions in her own health information in Tab 8, as follows:

> They wrote on the "genogram", "Left home at age 11, abused by father. Then they said, "Depression, in therapy since age 11," Then they wrote, "Disability: lupus (formerly in marketing/recruitment)." Then they said, "Past psychologist – [name of psychologist], in therapy since age 11, counseling for 13 years of marriage to [name of Applicant's ex-husband]." At another place on the page, it said, "Like father, like daughter" – [name of Applicant]."
>
> These statements were not about [name of Applicant's daughter's] childhood history or mental health history. I was the only one mentioned in these writings.

[para 68] *Tab 16 (10 severed pages)* - This typewritten report of an ACH psychologist is entitled, "Psychology Report" and "Behaviour Service: Outpatients" and is dated August 17, 2001. This report includes descriptions of the Applicant's perspective, the Applicant's ex-husband's perspective and the Applicant's daughter's perspective, and states:

> Background:
> The team's opinion was that the entire family required the services of the Family Therapy Program at the University of Calgary Medical Center. However, [name of Applicant] ([name of Applicant's daughter] mother) was very distraught at this recommendation, as she was quite insistent that there was something "seriously wrong" with [name of Applicant's daughter] … It was agreed that I would provide a psychological assessment in the interim while the referral to the University of Calgary Medical Center was proceeding. …
>
> There are extremely serious family problems. [Name of Applicant] has been in counselling for over 25 years. Though she insists that she has had sufficient counseling, her presentation in the initial interview was highly emotionally volatile and at one point she inferred she might end her life over her distress at her daughter's interactions with her. It was the opinion of the assessment team that [name of Applicant] needed to be transported to the Foothills Medical Center for an immediate evaluation and probable admission. [Name of Applicant] declined this suggestion and initially would give no reassurances that she would not harm herself. …
>
> After the initial assessment and before this assessment, the family was seen through the Emergency Department and subsequently the Consultation-Liaison Service on July 16/17. … These document a violent interaction between [name of Applicant's daughter] and her mother in which each accuses the other of significant harm. [Name of Applicant's daughter] and various family members were subsequently seen on a number of occasions by Dr. [name of physician], a psychiatric locum at Alberta Children's Hospital.

In terms of family history, [name of Applicant] indicates that she and [name of Applicant's ex-husband] were honour students and that [name of Applicant's ex-husband] has a substance abuse problem. Other than her brother having been arrested for drugs, [name of Applicant] does not identify any other problems in the background of either family. … [Name of Applicant] states she has systemic lupus. …

Summary and Conclusions:
[Name of Applicant], from the outset has held strong beliefs about there being significant pathology in both her daughter and her husband. She had already made her own diagnosis of both before the initiation of the assessment process and it was clear she was not seeking an independent opinion but a validation of her point of view. Furthermore at the time of completing questionnaires, she was facing accusations of physical and emotional abuse by her daughter. She had temporarily lost custody of her daughter, (functionally if not legally) and she and her husband had reported that they were "consulting their lawyers" about custody and access. Finally, she confided to Dr. [name of psychiatrist] that she faced financial loss (child support) and hardship if [name of Applicant's daughter] went to live with her father….

I have little doubt that [name of Applicant] sincerely believes that her daughter is seriously disturbed. … However, the best evidence I have is that these displays of emotion are confined to the home in general and [name of Applicant] in particular. They are in response to the failure of the relationship between [name of Applicant's daughter] and her mother to meet [name of Applicant's daughter's] needs and the failure of strategies that work in other settings. ….

Recommendations:
1) [Name of Applicant's daughter] and her mother need a cooling out period. … I have too little knowledge of both parents and their issues to make any recommendations in that regard. An assessment of both parents is warranted if there are to be any long-term decisions regarding [name of Applicant's daughter's] living arrangements.
2) Family therapy is strongly recommended to address the issues facing this family.

[para 69] Points 6 though 13 in the Applicant's written initial submission contain a number of corrections and amendments that the Applicant says pertain to alleged errors and omissions in her own health information in the above excerpts from Tab 16, for example:

I believe that the health services at Children's Hospital had been extended to the whole family including myself, since we were required to attend as a group. [Name of psychologist] wrote in his report, "The team's opinion was that the entire family required the services of the Family Therapy Program at the University of Calgary Medical Center." This statement implies that I, as part of the family was being provided with health services in the form of a recommendation, at Children's Hospital. That health service was in the form of "protecting, promoting or maintaining physical and mental health." It was also in the form of "diagnostic, treatment and care information." …

On page 1 of his report, [name of psychologist] states, "[name of Applicant] has been in counselling for over twenty-five years." This is absolutely untrue and I have no idea where [name of psychologist] got this information from. … If it is deemed that [name of psychologist's] statement about me being in therapy for twenty-five years is not an opinion, but a statement of fact, then I am repeating that my own personal health

> information has been recorded incorrectly. This statement made by [name of psychologist] was not about [name of Applicant's daughter]. It was my personal information that was recorded improperly and I want it to be corrected.

[para 70] *Tab 28 (4 severed pages)* - This typewritten report of an ACH psychiatrist is entitled, "Clinic Note/DAT Report" and "Mental Health Program". This report pertains to an outpatient visit of the Applicant's daughter at ACH on July 24, 2000. Tab 28 is the record pertaining to the corrections that CHR agreed to make in the ACH Records, which states:

> This second opinion was requested by her mother. … [Name of Applicant's daughter's] [name of Applicant's ex-husband] described that [name of Applicant's daughter] has had difficulties with her mother [name of Applicant].
>
> Although there have [sic] been no forensic history, but her mother did call the police about a week ago when , according to mother, [name of Applicant's daughter] was beating her up. … From the history obtained from the parents as well as from [name of Applicant's daughter], it did appear that she had difficulties only in the situation of home while she was living with her mother.
>
> On Axis I there is obviously a clear conflict between her mother and herself, giving rise to a [sic] parent-child relational problems. … On Axis IV there is the setting of chronic family dispute and a history of conflict with the mother.

[para 71] The 14th point in the Applicant's written initial submission describes the corrections and amendments the Applicant requests for alleged errors and omissions in her own health information in Tab 28. For example:

> Dr. [name of psychiatrist] stated that I pointed to my children and said my life with them had been a nightmare. I may have said my life had been a night mare [sic], but I did not point to my children and state that they had anything to do with that. I was referring to the fact that I left home at age 11 because of all forms of abuse from my father. … Dr. [name of psychiatrist's] report misstated what I said and since I was part of the group receiving health services, I would like that part of the record corrected. …
>
> On page 16 of my letter to [name of CHR employee] dated October 14, 2002, I said, "Dr. [name of psychiatrist's] report is also **full of error**. I met alone with Dr. [name of psychiatrist] on July 31, 2000, and at that time said my marriage to [name of Applicant's ex-husband] had been a night mare [sic] and it was! I clearly remember saying this. I never pointed to my children (because they were not even there) and said life with them was a nightmare. …"

[para 72] The Applicant says that Tab 28 contains errors because events are recorded that did not occur. For example:

> Dr. [name of psychiatrist's] report says, "As well I will also be meeting with the mother to further get some history and do some mental status examination." I wish this had happened, but it did not. If it had taken place a lot of the misconceptions about me would have been cleared up.

[para 73] *All ACH Records (20 severed pages)* - The Applicant's initial written submission says there are omissions in her own health information throughout the ACH Records because not enough information is recorded about her medical condition of Lupus. In regard to Tab 4 and Tab 5 the Applicant states, "The omission of my medical information and the medications I was taking, from a record that discusses my mental health is glaring."

[para 74] In regard to Tab 16 the Applicant says, "The omission about my lupus condition, my medications, and the difficulties in family life when a parent is chronically ill, are glaring. I would like the records to be corrected." In regard to Tab 28, the Applicant states:

> The record is devoid of any description of the severity of my health issues or the medications I was taking. … Even though Lupus and the medications used to treat it, can cause emotional or mood changes, not one of these professionals paused long enough to consider if that might explain my motivations or my behavior. They did not ask me a single question about my health, yet quickly made assumptions about me and then wrote them as fact. No one felt it would be worthwhile to take any time to interview me properly.

Records not at Issue (Non-ACH Records)

[para 75] The records not at issue shed some light on the question of whether the Applicant's requests pertain to the Applicant's own health information.

[para 76] *Information Pertaining to Other Alleged Errors and Omissions* – Tab 3, the letter to the Applicant from CHR that is dated December 20, 2002, describes the corrections that CHR agreed to make, as follows:

> The following corrections or amendments will [sic] made to the records:
>
> 1) [Name of psychiatrist's] report will be amended to show description of [name of Applicant's daughter] shouting in different voices.
>
> 2) [Name of psychiatrist's] report will be amended to reflect that the 200 beanie babies were obtained through doing chores for mother and as gifts from grandmother.
>
> 3) [Name of psychiatrist's] report will be amended to say that [name of Applicant's daughter] became suddenly slovenly and not gradually less tidy.
>
> 4) [Name of psychiatrist's] report will be amended to say "[name of Applicant's daughter] kicked me hard in the crotch with platform shoes" and not that she was "beating her up."

[para 77] Tab 17, the ACH psychologist letter to the Applicant, that is dated August 1, 2002, pertains to a meeting about concerns raised by the Applicant. An excerpt reads as follows:

> Fourth, you requested that a number of additions and corrections be made to the medical record, which you feel was based on inaccurate and/or inaccurate information. There are a number of problems with this that preclude us taking such action at this time. … some of the documents you provided have no bearing on [name of Applicant's daughter's] health care and would not be appropriate on a medical record.

[para 78] *Records Designated With Applicant's Daughter's Identifying Information* – Tab 6, the undated ACH Mental Health Program Family Information Sheet, begins with blank spaces for child's name, age, address, telephone, school, special class and number of schools attended. The introduction at the top of this form states:

> We would appreciate if you would complete this questionnaire to provide us with information which will help us to work with your child and family.

[para 79] Tab 7, the referral letter to ACH from the physician at the Bowmont Medical Clinic that is dated March 20, 2000, says:

> Her mother [name of Applicant] has been discussing with me episodes of "RAGE" in [name of Applicant's daughter]. … They have been occurring for years but have worsened recently with the death of her grandmother.

[para 80] Tab 18, the CHR psychologist letter to the Applicant that is dated June 30, 2000, reads:

> This letter is in follow-up of our initial meeting to set the date for the assessment of [name of Applicant's daughter] we discussed. The purpose of this assessment is to understand better [name of Applicant's daughter's] personality, behaviour and emotions.

[para 81] Tab 19, the ACH social work Outpatient Contact Note that is dated July 17 and 18, 2000, reads:

> [Name of Applicant] is not in favour of [name of Applicant's daughter] living with her dad. We offered to contact CW to assist in determining residence for [name of Applicant's daughter] and suggested that parents also call. …
>
> 2. [Name of Applicant] upset at the belief that a child welfare investigation has been launched and says she is charging [name of Applicant's daughter] with assault.
>
> 3. A support service for [first name of Applicant] is offered through CW should [name of Applicant's daughter] return to live with mom. Mom is angry stating that no helpful service has been provided.

[para 82] Tab 36, the ACH psychiatrist Outpatient Contact Note that is dated August 24, 2000, states:

> Patient Care Area: Children's Mental Health - Meeting with mom. Met with [name of Applicant's daughter's] mom. She stated that she was angry that no psychiatric diagnosis was made.

[para 83] *Records Designated With the Applicant's Identifying Information* - The Applicant provides four physician reports in Tab 24 and Tab 25, in support of the position that there are errors and omissions in her own health information in the ACH Records. These reports describe medical services being provided to the Applicant.

[para 84] *Tab 24* - The June 7, 2002 physician report describes a consultation or medical assessment of the Applicant at the Lupus Clinic, conducted by a University of Calgary rheumatologist. The March 5, 2001 physician report describes a consultation or medical assessment of the Applicant at the Rheumatic Diseases Clinic by a University of Calgary rheumatologist. This report includes family history that pertains to the medical services being provided to the Applicant, as follows:

> Her family history is significant for polyarteritis nodosa in her [family member]. Her [family member] died from lung cancer and was a heavy smoker. Her [family member] now has a photosensitive facial rash and has been investigated for lupus. However, her blood work is negative. There is no other family history of connective tissue disease that the patient is aware of.
>
> Her family life has been a great source of stress for the patient, and this often flares her symptoms. She is now divorced from her husband who has been quite threatening in the past. Her oldest daughter has become quite violent over the last one year, and despite repeated attempts to get help for her daughter, she has been unable to. Her daughter is now living with her father on her choice and is awaiting placement with Mental Health. The patient also has several financial concerns, which are causing her a great deal of stress as well.

[para 85] *Tab 24* - The June 24, 2005 physician report describes a consultation or medical assessment of the Applicant at the MS Clinic, by a Foothills Medical Centre neurologist. In addition to the above described information, the top left hand corner of the first page contains the Applicant's name beside "patient name" as well as the Applicant's HRN (health record number), age, health care number, gender, episode number and unit/clinic. This hospital report includes family history pertaining to the health services being provided to the Applicant, as follows:

> [Name of Applicant] was seen in consultation in hospital today. [Name of Applicant] is a [Applicant's age] woman with a 30 year history of collagen vascular disease, more specifically systemic lupus. … I note that she has been under investigation at length for symptom [sic] associated with lupus and has been followed in this regard by Dr. [name of physician]. … Often stress will precipitate these events and she certainly will be under some financial stress at present. I note that she is … divorced looking after two children.

[para 86] *Tab 29* - The December 20, 2001 physician report describes a consultation or medical assessment of the Applicant by a physician whose letterhead says "specialist in psychiatry". This report is a psychiatric assessment of the Applicant that includes family history pertaining to the medical services being provided to the Applicant, as follows:

> [First name of Applicant] is a [Applicant's age] married woman who has been separated from her husband [name of Applicant's husband] for three years after a twelve year marriage. They have two children. [Name of Applicant's daughter and age] and [name of Applicant's other daughter and age]. … While a large part of our discussion revolved around [Applicant's first name] family situation, assessment of her mental state revealed no evidence of a major mental illness currently. …
>
> [First name of Applicant] had a difficult upbringing, being mistreated by her mother, who isolated her from her siblings. Her father was an alcoholic. No one in her family was ever treated or hospitalized for psychiatric problems that [first name of Applicant] is aware of. She has always sought her mother's approval but received mixed messages from her. …
>
> [First name of Applicant] married her second husband [first name of Applicant's husband] at age thirty. The details of some of their chaotic thirteen year marriage are documented thoroughly by [first name of Applicant] in other documents so I will not describe them here. … When [first name of Applicant's] mother died in January, 2000, she was upset and took a "tranquilizer" for a short time … That said she has experienced a neglectful upbringing, disabling illness, a traumatic marriage and relationship with her eldest daughter as well as the loss of her mother approximately two years ago.

Custodian

[para 87] In its initial written submission, CHR responds to the questions that were raised in the Notice of Inquiry, as follows:

> The answer to questions 1, 2, 3, and 4, as stated in the Notice of Inquiry, is no. The Applicant did not request correction of her own health information pursuant to the *Health Information Act*, R.S.A. 2000, c. H-5 ("HIA").

[para 88] The Affidavit of CHR's Access and Privacy Coordinator describes CHR's position, as follows:

> I do verily believe that, as stated in my letter of October 2, 2006 (Exhibit C), the CHR does not have any records which are responsive to the OIPC request for "records pertaining to [name of Applicant's] health information when a health service was being provided to [name of Applicant]".

[para 89] In its written rebuttal submission, CHR says that the information the Applicant requested CHR to correct or amend in the ACH Records is not the Applicant's health information. In particular, CHR says that the information does not fall within the definition of "diagnostic, treatment and care information" in section 1(1)(i) of HIA or within the definition of "health information" in section 1(1)(k) of HIA, as those definitions pertain to information about the Applicant.

[para 90] CHR's written rebuttal submission replies to the Applicant's arguments, as follows:

The Applicant concedes that it was only [name of Applicant's daughter] that was referred to the Alberta Children's Hospital (the "ACH"). At page 3 of her Initial Submission, the Applicant states:

> I had gone to my family doctor and complained of difficulties that I personally, was having with [name of Applicant's daughter]. These difficulties were having a direct impact on my own medical condition. [Name of Applicant's daughter] was referred to the Children's Hospital based on my description alone …

The Applicant, in her own words, makes it clear that she obtained health services from her family physician, and her daughter was then referred to the ACH and received health services there. However, the Applicant is not seeking corrections to the records created by her family physician when she received a health service; she is seeking correction of her daughter's health record.

The Applicant describes what has been referred to as "family therapy" and suggests that "[t]o me this implies that a health service was being provided to all family members, me included." The Applicant's position appears to be that because she participated in the care and treatment provided to her daughter, that she too was receiving a health service. In fact, while family therapy is frequently part of the treatment of children, it is only the patient (in the [sic] case the Applicant's daughter) that is receiving a health service. The Applicant, despite her participation in same, did not receive a health service as part of the health services provided to her daughter.

[para 91] The psychiatrist's Affidavit in CHR's written rebuttal submission is provided by a consultant psychiatrist at CHR who provided health services to the Applicant's daughter at ACH. The Affidavit states:

> As part of a psychiatric assessment, and any follow up treatment or care to be provided to children such as [name of Applicant's daughter], there is often an evaluation of the patient which includes the patient and their family. This evaluation includes the patient's family in order to understand the family dynamic in the patient's life. While this evaluation includes family members of the patient, the only person being treated is the child.
>
> Any recommendations for "family therapy" are intended to treat the child, not the family. If the family unit benefits from the therapy as well as the child, that is a positive outcome as a family unit is an important part of a child's life and, therefore, improving the functioning of the family unit is positive for the care of the child patient. However, notwithstanding any benefits derived by any of the other family members, the only patient being treated during "family therapy" is the child patient.
>
> In particular, when [name of Applicant's daughter] attended at the ACH for "family therapy" it was only [name of Applicant's daughter] that was being treated, not her mother or any other family member that attended the therapy session.
>
> The Alberta Children's Hospital, as the name suggests, only treats children. If, during the treatment of a child it became apparent that an adult member of the family also required treatment, that adult would be referred to a physician at one of the adult acute care sites. [Name of Applicant] did not receive any diagnostic, treatment or care services as part of her daughter's diagnostic, treatment and care.

> I am aware, and was aware at all material times (including during the care and treatment of [name of Applicant's daughter]) of section 24(1) of the *Hospitals Act* which mandates that a patient record must be created for each patient receiving a health service. To the best of my knowledge, a health record for [name of Applicant] was not created by ACH during the treatment of her daughter as [name of Applicant] did not receive any diagnosis, treatment or care during this time.

Application

Must there be a "health service" for "diagnostic, treatment and care information" under HIA?

[para 92] The question of whether there must be a "health service" as defined in section 1(1)(m) in order for there to be "diagnostic, treatment and care information" as defined in sections 1(1)(i)(i) and 1(1)(i)(ii) of HIA, has not yet been considered in an Order under HIA. Section 1(1)(m) of HIA says that a "health service" means a service that is provided to an individual. Section 1(1)(m)(i)(C) of HIA says a "health service" is a service that is partly paid for by the Department that includes the purpose of diagnosing and treating illness.

[para 93] Section 1(1)(i) of HIA says "diagnostic, treatment and care information" *means* information about any of the six categories listed in sections 1(1)(i)(i) through 1(1)(i)(vi) *and includes* any other information about an individual that is collected when a "health service" is provided to the individual. The two HIA categories of "diagnostic, treatment and care information" that are relevant to the circumstances of this case, are information about the physical and mental health of an individual (section 1(1)(i)(i)) and information about a health service provided to an individual (section 1(1)(i)(ii)).

[para 94] The definition of "diagnostic, treatment and care information" in section 1(1)(i) of HIA contains both of the words, *means* and *includes*, even though these words usually signal different messages about intended meaning. Ruth Sullivan states:

> "Means" and "includes" have different uses. …
>
> > "Means" is appropriate for exhaustive definitions. … "Includes" is appropriate for two kinds of definitions; those that extend the defined term's usual meaning … and those that merely give examples of how the defined term's meaning without being exhaustive. … The drafter should exercise caution when using "includes". It should not be used in exhaustive definitions, and the contradictory "means" and "includes" should never be used. (Ruth Sullivan, *Sullivan and Driedger on the Construction of Statutes*, 4th ed., Markham Ontario: Butterworths, 2002, p. 619)

[para 95] Section 1(1)(i) of HIA begins with the word, *means*, which is to be read as an exhaustive definition. However, the last clause of section 1(1)(i) of HIA concludes with the word, *includes*, which is to be read as either extending the usual meaning or as merely giving examples of the meaning. Possible interpretations of the effect of the

clause at the end of the definition of "diagnostic, treatment and care information" in section 1(1)(i) of HIA, include:

- A "health service" provided to the individual is merely an example that *does not apply* to any of the six categories, so the "health service" mentioned in the concluding clause has the effect of creating an additional category; or

- A "health service" provided to the individual is merely an example that *may apply* to each of the six categories, so the "health service" mentioned in the concluding clause has the effect of creating an option that applies to each category; or

- A "health service" provided to the individual extends the meaning of and *applies* to each of the six categories, so the "health service" mentioned in the concluding clause has the effect of creating a mandatory requirement that applies to each category.

[para 96] In my view, information about a health service that is provided to an individual in section 1(1)(i)(ii) is different from "any other information" about an individual that is collected when a health service is provided to the individual, so the latter interpretation would not create a redundancy. When interpreting HIA, I must read the words in harmony with the scheme and the object and the entire context.

[para 97] Section 2 describes the scheme and purposes of HIA. Section 2(b) of HIA enables health information to be shared and accessed to provide health services and to manage the health system. Section 2(c) prescribes rules for the collection, use and disclosure of health information. HIA creates rights for individuals such as the right of access to their own health information (2(d)). HIA creates mechanisms to protect the privacy of individuals with respect to their own health information and with respect to the confidentiality of their own health information (2(a)).

[para 98] I must read the words in HIA harmoniously with the entire context. HIA establishes rules for the information about individuals that is collected and recorded as a result of the provision of health services in the publicly paid health sector. The ACH Records contain information that is collected when health services including psychiatric assessments are intended, are being provided or have been provided to the Applicant's daughter, as a mental health patient at a children's hospital.

[para 99] I must read the words in HIA harmoniously with the entirety of HIA. HIA applies only to information that is collected in the context of the provision of health services to individuals. HIA does not extend to information about non-health services. For example, section 1(2) of HIA says that where a custodian provides services that are not "health services", HIA does not apply to the custodian in respect of those other services or to information relating to those other services.

[para 100] In my view, the above considerations weigh in favour of an interpretation that the clause at the end of section 1(1)(i) of HIA that says, "and includes", is to be read as extending the usual meaning of the word, "means" at the beginning of this definition. This means that the latter option above is the better view and that a "health service" is

mandatory for each category of "diagnostic, treatment and care information" under section 1(1)(i) of HIA. Section 1(2) says that HIA does not apply to information where there is no "health service". For all of the above reasons, I find that there must be a "health service" that is provided to the individual in order for there to be "diagnostic, treatment and care information" under section 1(1)(i)(i) and section 1(1)(i)(ii) of HIA.

Does family history fall within the definition of "health information" under HIA?

[para 101] The question of whether the information in a family history is the "health information" of all family members and third parties involved or alternatively is only the "health information" of the individual that is receiving the "health service", has not yet been considered in an Order under HIA. HIA defines "health information" to include "diagnostic, treatment and care information" (section 1(1)(k)(i)).

[para 102] The terms in HIA that pertain to the meaning of "health information" are terms of art in that the Legislature has given these terms a special statutory meaning. These words do not have their ordinary or common meaning. I must interpret the words in accordance with the definitions in HIA. Health privacy legislation in other jurisdictions includes family history as a type of health information when the information pertains to the provision of health services to the individual.

[para 103] The health privacy legislation in Manitoba defines "personal health information" as information that relates to the individual's health and the provision of health care to the individual (*The Personal Health Information Act,* S.M. 1997, c. P33.5, section 1(1)). Similar to HIA, Manitoba includes information collected in the course of the provision of health care. In contrast to HIA, Manitoba expressly includes the information that is collected in the course of, but is incidental to, the provision of health care to the individual as well as the individual's "health care history".

[para 104] Similar to HIA, the health privacy legislation in Saskatchewan defines "personal health information" as information with respect to the physical or mental health of the individual and information with respect to any health service provided to the individual (*The Health Information Protection Act*, S.S. 1999, c. H-0.021) section 2(m)). Similar to HIA, Saskatchewan includes information collected in the course of provision of health services to the individual. In contrast to HIA, Saskatchewan expressly includes information that is collected incidentally to the provision of health services.

[para 105] Similar to HIA, the health privacy legislation in Ontario defines "personal health information" to include identifying information about an individual if the information relates to physical or mental health of the individual or relates to providing health care to the individual (*The Personal Health Information Act*, S.O. 2004, c. 3, Schedule A, section 4(1)). In contrast to HIA, Ontario expressly includes "health history of the individual's family" and "mixed records", which contain identifying information about the individual in a record of personal health information (section 4(3)).

[para 106] HIA Orders have consistently said there must be information *about* a health service that is provided to the individual in order for there to be "diagnostic, treatment and care information". For example, in Order H2004-002, an applicant requested access to third party information that included birthdates and home addresses of takedown team staff. The Commissioner found that this was not the applicant's "health information" as this was not information about a health service that was provided to the applicant, so the applicant did not have a right of access to the information under HIA.

[para 107] In Order H2004-004, the Commissioner found that there was "health information" about the applicant where the information at issue was a physician's note about the applicant that said, "i.e., 'Paranoid', 'Unable to get along with people', Personality disorder.'" However, although the Commissioner found that there was "health information", the Commissioner also found that the information consisted of professional opinion or observation and upheld the physician's refusal to correct or amend the "health information" under section 13(6)(a) of HIA.

[para 108] Orders F2004-005 & H2004-001 said that the information about third parties in the health, justice, law enforcement, corrections and legal systems that was recorded in the applicant's mental health hospital record was the applicant's "diagnostic, treatment and care information" because it was "any other information about an individual that was collected when a health service is provided to the individual"(paras 44-73). However, the Commissioner upheld the custodian's decision to withhold the "health information" under the harms test exception to access in section 11(1)(a)(ii) of HIA.

[para 109] The information recorded about third parties in a psychiatrist's notes in Order H2005-006 and the information recorded about third parties in a mental health hospital record in Order H2005-007, was found to be "health information" about the applicant. In those Orders, the Commissioner upheld the decision of the psychiatrist and the hospital to refuse to correct or amend under section 13(1) of HIA as the "health information" accurately reflected the impressions of health services providers so there were no errors or omissions, and also because, under section 13(6)(a) of HIA the "health information" was professional opinion or observation.

[para 110] In my view, all of the above considerations weigh in favour of a finding that family history falls within the definition of "health information" in HIA. Therefore, I find that when family history pertains to "diagnostic, treatment and care information" under sections 1(1)(i)(i) and 1(1)(i)(ii) of HIA, the information falls within the definition of "health information" in section 1(1)(k)(i) of HIA.

Is the Family History the Applicant's <u>own health information</u> under HIA?

[para 111] For simplicity, "Family History", includes all of the information in the ACH Records for which the Applicant requests correction or amendment. The parties are diametrically opposed about whether the Family History is the Applicant's own

health information or the Applicant's daughter's health information. The Applicant says that all of the Family History is her own "health information" and pertains to "when a health service was being provided to me personally". However, CHR says that all of the Family History is the Applicant's daughter's "health information".

[para 112] The specific circumstances must be considered when determining whether the Family History is the Applicant's own health information. In my view, the fact that a custodian agreed to make or refused to make a correction or amendment in response to an applicant's request, does not necessarily mean that this is an applicant's own health information. The custodian's response is not determinative, although it is a factor to consider. Some of the specific circumstances in this case are addressed in CHR's Affidavit from the psychiatrist who treated the Applicant's daughter at ACH.

[para 113] In the Affidavit, the psychiatrist says that the Applicant's daughter is the only individual who is receiving diagnostic, treatment and care services at ACH. The psychiatrist says that 'family therapy' and 'family evaluation' at ACH is treatment for the Applicant's daughter only and not treatment for the Applicant or the family. If the family benefits that is a positive outcome as the family unit is important to the child, but the only patient is the child. The psychiatrist says that the Applicant and other family members are not receiving treatment at ACH.

[para 114] The psychiatrist says that ACH is required to create a patient record for every patient receiving a "health service" at ACH. The ACH Records show that a patient record was created at ACH for the Applicant's daughter, but not for the Applicant. The identifying information on the ACH Records such as patient name, ACH number and Alberta health care number, pertain only to the Applicant's daughter. The Applicant concedes that all of the information that is the subject of the alleged errors and omissions is located only in her daughter's hospital record at ACH.

[para 115] The psychiatrist says that ACH is a children's hospital and only treats children. Where it becomes apparent that an adult family member also requires treatment during the treatment of a child, the adult is referred to an external or non-ACH adult care site. The ACH Records contain examples of this kind of situation. For example, it is recommended that the family obtain 'family therapy' at the University of Calgary family therapy program. It is also recommended that the Applicant obtain an ER (Emergency Room) assessment at Foothills Hospital and see her own psychologist.

[para 116] I accept the psychiatrist's Affidavit evidence that the 'family therapy' and 'family evaluation' described in the ACH Records pertain only to a "health service" that is provided to the Applicant's daughter. ACH is a children's hospital that does not provide health services to adults. At ACH, it is only the child who has a hospital record and who is receiving a health service, even when the services entail the collection of Family History. The psychiatrist's evidence weighs in favour of a finding that it is only the Applicant's daughter who is receiving a "health service" and who is the subject of the "health information" in the ACH Records.

[para 117] In some respects, the records speak for themselves. The notations in the ACH Records consistently refer to the Applicant as the "mother" or "parent". The ACH Records refer to the Applicant's daughter as the "patient" and as the "child" receiving the health services. The ACH Records say that the Applicant's daughter is referred to ACH for psychiatric assessment, not the Applicant. The appointment at ACH for the psychiatric assessment is for the Applicant's daughter, not the Applicant. The Family Information Sheet in Tab 6 pertains to the psychiatric assessment of the Applicant's daughter, not the Applicant. The Psychology Report in Tab 16 says there is "too little information" to make any recommendations about the parents.

[para 118] The ACH Records are designated with the Applicant's daughter's name and identifying information, rather than with the Applicant's identifying information. The information about the Applicant in the ACH Records is written in the context of providing a "health service" to the Applicant's daughter. For example, the notations about a 'safety plan' and living arrangements are relevant to the Applicant's daughter's safety, as the daughter is returning home with her mother. The Family History weighs in favour of a finding that only the Applicant's daughter is receiving a "health service".

[para 119] In contrast to the ACH Records, the Applicant's physician reports in Tab 24 and Tab 29 are designated with the Applicant's identifying information. The "Re:" lines in the Applicant's physician reports refer to the Applicant. These reports provide a detailed description of medical services being provided to the Applicant including the management of the medical condition of Lupus and a psychiatric assessment. The Applicant's physician reports contain family history pertaining to many family members including the Applicant's ex-husband and the Applicant's daughter. The Applicant's physician reports contain information that is collected when a health or medical service is being provided to the Applicant.

[para 120] In contrast to the 'family therapy' and 'family evaluation' provided to the Applicant's daughter at ACH, the ACH Records recommend therapy for the entire family at the University of Calgary Family Therapy Program. In contrast to the health services provided only to children at ACH, the family therapy at a different health facility could entail the provision of joint health services and a joint health record for all family members. The above factors weigh in favour of a finding that the Family History does not pertain to providing health services to the Applicant or other family members, but only to the Applicant's daughter.

[para 121] At first glance, it may seem odd that information the Applicant provided to ACH about herself and other family members would not be the Applicant's "health information" under HIA. The Applicant was the source of most of the Family History in the ACH Records. However, the source of the information is not a relevant factor in the HIA definitions of "health service", "diagnostic, treatment and care information" and "health information". What is relevant is whether the situation falls within the definition of "diagnostic, treatment and care information" as "any other information that is collected when a health service is provided to the individual" in section 1(1)(i) of HIA.

[para 122] It may also seem odd that information *about* the Applicant and *about* other family members would not be their own "health information" under HIA. The Family History pertains to all family members insofar as they share the same history. In that sense, the information is *about* the Applicant as well as *about* the Applicant's daughter and *about* all other family members. However, Family History must be considered in the context of the purpose for which the information is collected, which is to provide a "health service" to the Applicant's daughter. Therefore, the Family History is *about* a "health service" provided to the Applicant's daughter, not to the Applicant.

[para 123] The Applicant says that the Family History contains her own "health information" because there is information *about* her. The logical extension of the Applicant's argument is that health records are the health information of every third party mentioned. A health record, particularly a mental health record, may refer to scores of third parties. If I were to adopt the Applicant's argument, this would mean that health records are the "health information" of numerous individuals. This would mean that all individuals mentioned in the Applicant's physician reports, such as the Applicant's daughter and ex-husband, could exercise rights over the Applicant's health information. I do not believe that this is what the Legislature intended.

[para 124] HIA defines a "health service" as a service that is provided to an individual that is partly paid by the Department (of Alberta Health and Wellness) that includes diagnosing and treating illness (section 1(1)(m)(i)(C)). One way to track the delivery of health services so that the Department can pay for the services is to create a record for every individual that receives a health service. There is no evidence before me to suggest that the Family History pertains to a "health service" provided to the Applicant that is partly paid for by the Department under section 1(1)(m)(i) of HIA. The existence of the ACH Record for the Applicant's daughter is an indication that the Department partly paid for the services provided to the daughter and that this is a "health service" under section 1(1)(m)(i) of HIA.

[para 125] HIA defines "diagnostic, treatment and care information" to include information about physical and mental health of an individual and about a health service provided to an individual and any other information about an individual that is collected when a "health service" is provided to the individual (sections 1(1)(i)(i) and 1(1)(i)(ii)). Under HIA, in order to be an individual's "diagnostic, treatment and care information", and therefore, the individual's "health information", the information must be *about* a "health service" provided to the individual. HIA is not unique in including family history within the legislative definition of health information.

[para 126] In my view, all of the Family History is *about* the Applicant's daughter and in particular is *about* a health service that is being provided to the Applicant's daughter. The sole reason the information is recorded in the Applicant's daughter's hospital record is because the information is relevant to providing a "health service" to the Applicant's daughter. As the Applicant is not receiving a "health service" under section 1(1)(m), this is not the Applicant's "diagnostic, treatment and care information" under section 1(1)(i) or the Applicant's "health information" under section 1(1)(k) of HIA.

[para 127] There must be "health information" that falls within the definition of "diagnostic, treatment and care information" that is collected when a "health service" is provided to the Applicant in order for the Family History to be the Applicant's own "health information". I accept CHR's submission that the Family History is not the Applicant's "health information", but rather, this is the Applicant's daughter's "health information". I find that the Family History is not the Applicant's own "health information".

[para 128] Having considered all of the information in the ACH Records as well as all of the facts, evidence and argument provided by the parties at the Inquiry, I find that in the circumstances of this case the Applicant did not receive a "health service", as defined in section 1(1)(m) of HIA. Consequently, I find that the Family History is not the Applicant's "diagnostic, treatment and care information", as defined in section 1(1)(i) of HIA. Therefore, I also find that the Family History is not the Applicant's own "health information", as defined in section 1(1)(k) of HIA.

[para 129] For all of the above reasons, I find that the Applicant failed to discharge the burden of proof to show that the requests pertain to the Applicant's *own health information*. I find that family history can fall within the definition of "health information" under HIA, but the Family History in this particular case is not the Applicant's own "health information". Therefore, I find that the answer to the second part of Issue A is "no", in that the Applicant's request did not pertain to the Applicant's *own health information*.

Summary

[para 130] These findings mean that the answer to all of Issue A is "no", in that the Applicant made a *request* for correction or amendment, but the request did not pertain to the Applicant's *own health information*.

[para 131] In my view, this finding is consistent with other purposes of HIA such as the rights of individuals over their own health information for correction or amendment (section 2(e)) and for remedies for contravention of HIA (section 2(f)). This is not a situation where there is no right to request correction or amendment or no right to pursue remedies under HIA. However, it is the Applicant's daughter, rather than the Applicant, who has the authority to exercise the rights and powers over the Applicant's daughter's own health information in the ACH Records.

[para 132] This finding is also consistent with reading HIA in its entirety. HIA protects the privacy of individuals as well as the privacy of third party information. For example, HIA exceptions to access include disclosures that could reasonably be expected to result in harm (section 11(1)(a)), that could reasonably lead to the identification of a person who provided health information in confidence (section 11(1)(b)) and that involve the health information of another individual (section 11(2)(a)). CHR applied all of these provisions to the information that it severed from the ACH Records.

ISSUE B: IF THE ANSWER TO ISSUE A IS YES, IS THE HEALTH INFORMATION OF THE APPLICANT TO WHICH THE REQUEST PERTAINS IN THE CUSTODY AND CONTROL OF THE CUSTODIAN WITHIN THE TERMS OF SECTION 13(1) OF HIA?

[para 133] Given my decision that there is no "health information" of the Applicant and the answer to Issue A is "no", I find that there is no issue to consider under Issue B, as to whether the health information was in the custody and control of the Custodian within the terms of section 13 of HIA.

ISSUE C: IF THE ANSWERS TO ISSUES A AND B ARE YES, DID THE CUSTODIAN REFUSE TO MAKE THE CORRECTIONS OR AMENDMENTS TO THE APPLICANT'S HEALTH INFORMATION THAT SHE REQUESTED?

[para 134] Given my decision that there is no "health information" of the Applicant and the answer to Issue A is "no", I find that there is no issue to consider under Issue C, as to whether the Custodian refused to make the corrections or amendments to the Applicant's health information that she requested.

ISSUE D: IF THE ANSWER TO ISSUE C IS YES, WAS THE CUSTODIAN'S REFUSAL TO CORRECT OR AMEND THE APPLICANT'S HEALTH INFORMATION AUTHORIZED BY SECTION 13 OF HIA?

[para 135] Given my decision that there is no "health information" of the Applicant and the answer to Issue A is "no", I find that there is no issue to consider under Issue D, as to whether the Custodian's refusal to correct or amend the Applicant's health information was authorized by section 13 of HIA.

VI. ORDER

[para 136] I make the following Order under section 80(3)(d) of HIA*:*

- In regard to the issues that are before me at the Inquiry, I find:
    - Issue A: Did the Applicant request correction or amendment of her own health information?
        - I find that the Applicant made a *request* for correction or amendment;
        - I find that the request pertained to the Applicant's daughter's "health information", but not to the Applicant's *own health information*; and

- Therefore, I find that the answer to Issue A is "no", the Applicant did not request correction or amendment of her own health information.

- Issue B: If the answer to Issue A is yes, is the health information of the Applicant to which the request pertains in the custody and control of the Custodian within the terms of section 13(1) of HIA?

    - Given my decisions that there is no health information of the Applicant and the answer to Issue A is "no", I find that there is no issue to consider under Issue B, as to whether the health information was in the custody and control of the Custodian within the terms of section 13 of HIA.

- Issue C: If the answers to Issues A and B are yes, did the Custodian refuse to make the corrections or amendments to the Applicant's health information that she requested?

    - Given my decisions that there is no health information of the Applicant, the answer to Issue A is "no" and there is no issue to consider under Issue B, I find that there is no issue to consider under Issue C, as to whether the Custodian refused to make the corrections or amendments to the Applicant's health information that she requested.

- Issue D: If the answer to Issue C is yes, was the Custodian's refusal to correct or amend the Applicant's health information authorized by section 13 of HIA?

    - Given my decisions that there is no health information of the Applicant and no issue to consider under Issue C, I find that there is no issue to consider under Issue D, as to whether the Custodian's refusal to correct or amend the Applicant's health information was authorized by section 13 of HIA.

- Given my finding that there is no health information of the Applicant, I confirm the Custodian's decision not to correct or amend the information under section 13 of HIA.

Noela Inions, Q. C.
Adjudicator