FREEDOM OF INFORMATIN AND
PROTECTION OF PRIVACY

REQUEST FOR CORRECTION OF PERSONAL INFORMATION

Request No. _____

Request Code _____

NAME OF PUBLIC BODY TO WHICH YOU ARE DIRECTING YOUR REQUEST	
❑ Peace River Regional District	❑ Peace River Regional Hospital District

YOUR NAME		
Last Name	First Name	Middle Name

YOUR ADDRESS			
Street, PO Box, RR No.	City/Town	Province/Country	Postal Code

YOUR TELEPHONE / FAX NUMBERS		
Day Phone No. ( )	Alternate Phone No. ( )	Fax No. ( )

DETAILS OF REQUESTED INFORMATION

Correction requested. (Please describe the personal information you want corrected. Attach any supporting documentation. Attach a separate sheet if the space below is not sufficient. Please specify any reference or file numbers, if known.

Are you making a request for correction of personal information on behalf of another person? ❑ Yes ❑ No
(If so, please attach a signed letter of authorization or other proof of authority to act.)

Your Signature	Date Signed		
	Year	Month	Day

FOR PUBLIC USE ONLY

Date Received:	Request Category	Correction of Personal Information ❑ (ARCS 293-200 _____)

Name of Public Body Receiving Request:

You may make a request for correction without using this form, provided you do so in wiring.
Personal information contained on this form is collected under the *Freedom of Information and Protection of Privacy Act* and will be used only for the purpose of responding to your request.