



OFFICE OF THE INFORMATION
AND PRIVACY COMMISSIONER
NEWFOUNDLAND AND LABRADOR

Report AH-2026-002

September 29, 2026

Newfoundland and Labrador Health Services

Summary:

The Complainant made a request for correction of their personal health information to Newfoundland and Labrador Health Services (NLHS). NLHS refused to grant the request for correction, instead choosing to annotate the record. The Complainant filed a complaint with this Office regarding the custodian's decision to refuse to correct their personal health information. The Commissioner found the custodian has appropriately refused to correct the record and has fulfilled its statutory obligation to annotate the record with the corrections requested but not made.

Statutes Cited:

Personal Health Information Act, SNL 2008, Chapter P-7.01, sections 3, 62, and 63.

Authorities Relied On: NL OIPC Reports [A-2026-016](#) and [AH-2026-001](#)

AB OIPC Orders [F2016-34](#), [H2016-03](#), [H2004-004](#), [H2022-02](#), [98-010](#)

ON IPC PHIPA Decision [285](#), [36](#),

[Covenant Health v. Alberta \(Information and Privacy Commissioner\)](#), 2014 ABQB 562

BACKGROUND

- [1] In November of 2024 the Complainant submitted a request for correction of their personal health information under the **Personal Health Information Act** (“PHIA”) to Newfoundland and Labrador Health Services. In November of 2025, NLHS provided written notification to the Complainant that it had refused the request for correction and instead annotated the record.
- [2] The Complainant was not satisfied with NLHS’s refusal of the request for correction and decision to annotate the record and filed a complaint with this Office.
- [3] Upon review, this Office found NLHS had not sufficiently annotated the record with the corrections that were requested but not made as required under section 63(2) of PHIA. During informal resolution efforts, NLHS agreed to add an additional annotation to the record which summarized the corrections requested
- [4] As the Commissioner was unable to obtain the Complainant’s consent to resolve this matter informally, the Commissioner conducted a review of the subject matter of the complaint in accordance with section 67(2) of PHIA.

CUSTODIAN’S POSITION

- [5] NLHS explained that the request for correction was refused on two grounds. First, NLHS stated the Complainant did not demonstrate to the satisfaction of NLHS that the record was incomplete or inaccurate for the purposes for which the custodian uses the information (in this case the provision of care) as required by section 62(1)(a)(i) of PHIA. NLHS maintained that the core of the Complainant’s request was to correct information provided by third-party family members that the Complainant believed to be inaccurate and incomplete. NLHS noted, however, that much of the information marked by the Complainant was more commentary characterizing the nature of the information rather than exposing information inaccuracies or incompleteness related to the provision of care. Second, NLHS stated that it refused the correction request because it consists of opinions or observations that were provided by a third party to the custodian about the individual.

[6] NLHS also argued multiple points concerning how it chose to annotate the record. It maintained that many of the requested corrections, which noted the Complainant's disagreement with the health professional's observations, could already be deduced from the record itself. To further annotate the record with the Complainant's disagreement or dissatisfaction would be unnecessary. NLHS also argued the Complainant did not provide information necessary to support annotations. As the Complainant only expressed disagreement in many cases, there was little information to form the basis of an annotation. Lastly, NLHS took the position that properly placed annotations are most effective when brief, focused, concise, and presented in a way that users of the system are accustomed to.

COMPLAINANT'S POSITION

[7] The Complainant sought correction of over 48 identifiable topics within their medical records and had over 60 items marked for correction. Much of the information the Complainant sought to have corrected was information provided by third parties which the Complainant disagreed with or believed to be incorrect.

ISSUES

[8] The issues to be addressed in this report are:

1. Did the custodian appropriately refuse the Complainant's request for correction?
2. Did the custodian appropriately annotate the record with the corrections that were requested but not made as required under section 63(2) of PHIA?

DECISION

Issue 1 - Did the custodian appropriately refuse the Complainant's request for correction?

[9] NLHS chose not to make any corrections to the Complainant's medical record, citing section 62(1)(b)(ii) of PHIA which states the custodian may refuse the request for correction where:

62(1)(b)(ii) the information which is the subject of the request consists of a professional opinion or observation that a custodian has made in good faith about the individual . . .

[10] NLHS argued that the information subject to the request for correction consisted of opinions and observations that were provided by a third party to the custodian about the individual. NLHS stated it could not determine the validity of the statements but relies on professional opinion and observation, documentation standards, and standards set by the College of Physicians and Surgeons which support the use of collateral information to inform clinical decision-making. Physicians are expected to exercise clinical judgment in determining what information is necessary to provide appropriate care, and to document relevant information in the patient's chart.

[11] The purpose of section 62(1)(b)(ii) is to preserve professional opinions and observations, accurate or otherwise, that have been made in good faith. It is based on the need for documentation which serves to explain and support diagnoses and treatment by health professionals.

[12] In Order [H2016-03](#) the Alberta OIPC provided the following definitions for what can be considered a professional opinion or observation:

“Professional” means a belief or assessment based on grounds short of proof, a view held as probable (Order [H2004-004](#)). “Observation” means a comment based on something one has seen, heard, or noticed, and the action or process of closely observing or monitoring (Order [H2004-004](#)).

[13] A professional opinion or observation does not speak to the truthfulness or accuracy of its contents but rather to the author's impressions and understanding of the situation. This has been upheld in multiple jurisdictions; including the Alberta OIPC (see Order [H2016-03](#)) and the Information and Privacy Commissioner of Ontario (see PHIPA Decision [285](#)).

[14] To determine whether section 62(1)(b)(ii) applies, a two-part analysis adopted by the Ontario IPC in PHIPA Decision [36](#), should be considered. The first part of the test is whether the personal health information is a ‘professional opinion or observation’ and the second part is whether the opinion or observation was made in ‘good faith’.

[15] I find that some of the records to which the Complainant sought correction contain a health care professional's medical assessment or diagnosis of the patient. This falls squarely into the meaning of a professional opinion or observation. No evidence was presented, or found, to suggest the opinion or observation of the health care professional was made in bad faith. As such, I conclude regarding the portions of the records which clearly consist of medical assessments that it was appropriate for the custodian to refuse to correct the records under section 62(1)(b)(ii) of PHIA.

[16] Much of the records to which the Complainant sought correction involved descriptions of the Complainant's habits at home, family dynamics, financial and work history, and other background information, provided by either the medical professional or a third party, such as a family member. The Ontario IPC has determined in PHIPA Decision [36](#) that although these types of observations are about background information, rather than clinical matters; if they are not merely a transcription of the information conveyed by the Complainant but involve judgement and discernment and therefore, the exercise of special knowledge, skills, qualifications, or judgment by a professional they qualify as professional observations. A report by the Alberta OIPC further concluded, in Order [H2022-02](#), that a health professional is recording a professional observation when recording information about a patient, even when that information is provided by a patient's family member. The Alberta OIPC stated:

This conclusion is supported by the Court of Queen's Bench decision, *Covenant Health v. Alberta (Information and Privacy Commissioner)*, [2014 ABQB 562](#), in which the Court determined that information provided by someone other than the patient is still the patient's health information if it is collected for the purpose of providing health services to the patient (see para. 74).

[17] I find that the background information, whether provided by the Complainant or a third party, was presumably collected by the health professional to discern appropriate treatment, diagnosis, or render other provisions of care. It therefore involved the judgment and exercise of specialized knowledge of the medical professional and should be considered a professional opinion or observation. As such, the custodian had the authority to refuse to correct any portions of the record involving background information of the Complainant under section 62(1)(b)(ii) of PHIA.

[18] While the custodian also argued that the record should not be corrected on the grounds that the Complainant did not demonstrate to the satisfaction of NLHS that the record was incomplete or inaccurate as required by section 62(1)(a)(i) of PHIA, I find it not necessary to consider this argument given that it has already been established that the record should not be corrected.

Issue 2 - Did the custodian appropriately annotate the record with the corrections that were requested but not made as required under section 63(2) of PHIA?

[19] Section 63 (Duty of Custodian) of PHIA requires that:

- (2) Where a custodian refuses to grant a request for correction under paragraph 62(1)(b), he or she shall
 - (a) annotate the personal health information with the correction that was requested and not made and, where practicable, notify a person to whom the information was disclosed within the 12 month period immediately preceding the request for correction of the notation unless the custodian reasonably expects that the notation will not have an impact on the ongoing provision of health care or other benefits to the individual or the individual requesting the correction has advised that notice is not necessary; and
 - (b) provide the individual requesting the correction with a written notice setting out the correction that the custodian has refused to make, the refusal together with reasons for the refusal, and the right of the individual to appeal the refusal to the Trial Division under Part VII or request a review of the refusal by the commissioner under Part VI.

[20] Upon the initial request for correction NLHS advised the Complainant it would annotate the medical record. The annotations added by NLHS, while appropriate, did not capture all of the identifiable topics the Complainant sought correction to.

[21] NLHS took the position that annotations properly placed are most effective when brief, focused, concise, and presented in a way that users of the system are accustomed to. That is, the custodian should not be forced to comply with unreasonable demands but rather annotate the record in a fair manner. Additionally, NLHS argued in relation to this file, that annotation would not reasonably be required where the Complainant's disagreement with the health professional's observations can be deduced from the record itself. NLHS states to further annotate the record would be unnecessary.

[22] NLHS also argued that:

Correction requests can be quite challenging when the substance of a correction request is insufficient, and one is left with merely the expression of disagreement with little else to even form the basis of an annotation. . . Where factual inaccuracies are determined, corrections are made. However, the requests here didn't meet the test of legislation as per PHIA S62(1). In most instances, the complainant didn't demonstrate to the satisfaction of NL Health Services that the record was incomplete or inaccurate for the provision of care nor, in most cases, provide information necessary to support annotations.

[23] I disagree with NLHS's argument that the Complainant did not provide information necessary to support annotation and that as the Complainant only expressed disagreement in many cases, there was little with which to form the basis of an annotation. I accept that under section 62 of PHIA the burden of proof lies with the Complainant to demonstrate to the satisfaction of the custodian that the record is incomplete or inaccurate in order for a correction to be made. However, I find the same argument cannot be applied to an annotation. To add an additional burden of proof on the Complainant to also provide sufficient information to support an annotation would be unreasonable. I also find the custodian would bear the burden here to seek further clarification from the Complainant should it not be understood what the Complainant is asking to be corrected or annotated. While there is no explicit duty to assist under PHIA, there is an implied duty on the part of custodians to facilitate access to rights granted under the statute.

[24] Section 63 of PHIA, taken at face value, is clear that the personal health information of the individual must be annotated with the correction that was requested and not made; however, I do not believe the intention of this section was to force a custodian to make a plethora of annotations to a single medical chart. Correction and annotation must be interpreted in light of the purpose of the statute and within the context of the statute as a whole. As noted recently in Report [AH-2026-001](#):

The annotation process is not a carte blanche invitation for patients to have their views recorded by a custodian in the patient record. The proposed annotation must be directly related to the information that was the subject of the correction request, and it must only address those aspects of the record that the individual believes are inaccurate or incomplete. The annotation process is not an opportunity to editorialize broadly about the custodian or staff or other patient care issues that are unrelated to the record that was the subject

of the correction request. Custodians may therefore omit from the annotation any commentary that is clearly not related to the accuracy or completeness of the record that was the subject of the correction request. Additionally, when a large number of related corrections are requested but not made, it may be reasonable for the Custodian to make a general annotation acknowledging the correction request and specifying the types of corrections requested.

[25] Section 3(c) of PHIA provides individuals with a right to require the correction or amendment of personal health information about themselves, subject to limited and specific exceptions as set out in the Act. While annotation is an obligation on the part of a custodian, it is not a right on the part of the individual. It can be interpreted that the purpose of the annotation is not to fulfil a right, but to carry out an obligation, and this obligation must be fulfilled in such a way that does not interfere with the custodian's ability to carry out its core purpose of delivering health care. An essential part of this is ensuring that records are intelligible and readily understandable. A custodian should therefore carry out a request for annotation up to the point that it could impact the ability of the custodian to do its work, but not beyond that point.

[26] In this case, the custodian cannot reasonably be expected to annotate a record over 60 times while ensuring the record remains legible. A concise and well-presented annotation would better achieve the objects of the Act and the purpose of annotation, without impairing the ability of NLHS to deliver health care.

[27] I also agree with NLHS that where the record itself already reflects the individual's disagreement with the health professional's opinion or observation, those elements of the annotation are already present and need not be added a second time.

[28] During informal resolution efforts, NLHS agreed to add an additional annotation to the record which summarized the remaining corrections requested but not made. This summary is a reasonable and concise means for the custodian to annotate the record while still capturing the identifiable topics the Complainant sought correction to.

[29] I am satisfied that the custodian has met its duty under section 63(2)(a) to annotate the record with the correction that was requested and not made.

RECOMMENDATIONS

[30] Under the authority of section 72(3) of the **Personal Health Information Act**, in this particular case I make no recommendation.

[31] Dated at St. John's, in the Province of Newfoundland and Labrador, this 29th day of September 2026.



Kerry Hatfield
Information and Privacy Commissioner
Newfoundland and Labrador