Requested Amendment/Correction of Protected Health Information

Patient name:_____ Date of Birth:_____

Patient Previous Last Name:_____ Medical record/Account number:_____

Patient address:_____ Telephone Number:_____

_____

Patient email address: _____

Date of entry to be amended:_____ Type of entry to be amended:_____

Please explain how the entry is incorrect or incomplete. What should the entry say to become more accurate or complete?

_____

_____

_____

_____

I authorize the release of the amended information described herein to the following parties (Information will only be sent to Name/ Business specifically identified below):

Name/Business:_____ Address:_____

Name/Business:_____ Address:_____

_____ _____

Signature of Patient or Personal Representative Date

****Please attach any copies of supporting documentation associated with your request to amend/correct your PHI****

PURPOSE:
This form is used to request an amendment/Correction to information in your medical record. You may expect a response from us within sixty (60) days of receipt of a completed request. If for some reason we are unable to respond to your request within this time frame, we will contact you in writing with the reason for the delay as well as the date by which action on your request will be completed (no later than thirty (30) days from the original date of response).

For hospital use only:

Date Received:_____ Amendment has been: _____Accepted _____Denied

If denied, check reason(s) for denial:

_____PHI not created by this organization

_____PHI not part of designated record set

_____PHI is accurate and complete

_____PHI not available to patient for inspection as required per Federal law (e.g. psychotherapy notes)

Comments of Healthcare Practitioner:

_____

_____

_____

_____ _____

Printed Name of Healthcare Practitioner Signature Name of Healthcare Practitioner

Date:_____