Request Amendment to Protected Health Information

Please print all requested information to prevent delays in our response & provide completed form to your facility.

Patient Name: _____
Last First MI Maiden or Other Name

Address:_____City:_____ST:____Zip:_____

Date of Birth: _____-_____-_____ Phone: _____

Entry to be amended: Date:_____Correction Type:_____

Explain how the entry is incorrect or incomplete and what it should say to be correct.

_____

_____

Would you like this amendment or denial sent to anyone we may have disclosed the information to in the past? If yes, please provide name and address information.

NAME: _____

ADDRESS: _____CITY:_____STATE:_____ZIP:_____

I understand that my request will be processed within the time frames set forth by state law or within 60 days, whichever less is.

SIGNATURE OF PATIENT **DATE**

OR

PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON **DATE**

RELATIONSHIP TO PATIENT **DATE**

Request Amendment to Protected Health Information (PHI)

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FOR INTERNAL USE ONLY

Complete the sections below and place with patient records.

Date Request Received:_____ ❑ mail ❑ in person ❑ email ❑ fax

Amendment Request has been: ❑ Accepted ❑ Denied

If denied, reason for denial is:
- ❑ Information was not created by this organization
- ❑ Information is not a part of patient's designated record set
- ❑ Information is not available to the patient for access as required by federal law
- ❑ Information is complete and accurate

Comments: _____

Signature of Staff Member	**Title**	**Date**	**Phone**

Facility Name