REQUEST FOR AMENDMENT OR CORRECTION OF PROTECTED HEALTH INFORMATION

Patient Name:		Request Date:	
Mailing Address:		Birth Date:	
City/State/Zip:		MR/Account #:	

WHAT NEEDS TO BE AMENDED/CORRECTED & WHY

Entry to be amended:	
Date & Author of entry:	

Please explain how the information is incorrect or incomplete. What should the information state to be more accurate or complete?

Would you like this amendment sent to anyone to whom we may have disclosed this information in the past? If so, please specify the name and address of the organization or individual.

I understand that the provider may or may not amend the medical record with an amendment based on my request, and under no circumstances is the provider permitted to alter the original medical record. In any event, this request for an amendment will be made part of my permanent medical record.

_____ _____

Signature of Patient or Patient's Legal Representative Date

FOR HEALTHCARE ORGANIZATION/INTERNAL USE ONLY

Date received:	❑ Accepted	❑ Denied

If denied, check reason for denial:

- ❑ PHI was not created by this organization
- ❑ PHI is not available to the patient for inspection as permitted by federal law (e.g., psychotherapy notes)
- ❑ PHI is not part of patient's designated record set
- ❑ PHI is accurate and complete

Comments:

- ❑ Individual was informed of denial in writing (attach letter of communication)

_____ _____

Signature/Title of Staff Member Date