Request for Amendment of Health Information

Patient Name: ____ Date of Birth: ________________________________

MRN: ______________________ Account #: ________________ Phone: ____

Patient Address: ____

Date of Entry to be Amended: _____________ Type of entry to amend: ____

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

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Please list below persons who have received health information about you and need to be made aware of the amendment, if your amendment request is accepted. Please specify the name, address and phone number:

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_______________________________________ ______________________ ___________________________________

Signature of Patient or Legal Representative Date Relationship of Legal Representative

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Facility Amendment Decision - Staff Use Only

Date request received: ____________________ Amendment: _____ Accepted _____ Denied

If accepted, Patient notified on _______________ by ____.

Date **Workforce Member**

If denied, check reason for denial:

____ PHI was not created by this organization ____ PHI is not part of the patient's medical record

_____ PHI is accurate and complete ____ Other reason (describe):________________________________

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Comments, if any: ____

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Date notification mailed to Patient/Legal Representative:_______________________________________

(Note: Notification must be mailed within 60 days of receipt of request. If request is denied, include a copy of the Patient Rights Denial Letter.)

Signature of Authorized Personnel

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