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.

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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 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 INDIVIDUAL	

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

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Facility Name