PATIENT REQUEST FOR MEDICAL RECORD/PHI AMENDMENT

Patient Name: ____ Patient Date of Birth: __________________

Patient Address:

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Medical Record Number: ______________________ Date of Entry to be Amended: ___________________

Explain how the information entered on your health record is incorrect or incomplete. Include what the information should say to be more accurate or complete.

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Do you need this amendment sent to anyone to whom we may have disclosed the information in the past? If so, please indicate the name and address of the individual or organization.
Name and Address:

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_______________________________________ _______________________________________
Signature of Patient or Personal Representative Date

_______________________________________ _______________________________________
Printed Name of Personal Representative Relationship to Patient

For Health Information Department Use Only:

Date Amendment Request Received: _________________ Amendment Status: ____ Accepted ____ Denied

If the Amendment Request is denied, check reason for denial:

____ The Protected Health Information (PHI) was not created by this organization

____ The Protected Health Information is not available to the patient for inspection as required by law (e.g., psychotherapy notes).

____ The Protected Health Information is not part of the patient's medical record
____ The Protected Health Information is accurate and complete

Name of Staff Member: ____ Title: ______________________

Comments of Healthcare Practitioner:

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Signature of Healthcare Practitioner Date/Time