Request for Correction/Amendment of Protected Health Information

Patient Name:		Today's Date:	
Patient Address:		Patient Date of Birth:	
Best # to reach you:		MR/Acct #:	

What Needs To Be Corrected/Amended & 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? (Use additional paper if more room is needed)

If this amendment is accepted, would you like this amendment sent to anyone else who received the information in the past? ☐ **Yes** ☐ **No**

If yes, please specify the name and address of the organization(s) or individual(s):

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 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 request received in HIM:	Healthcare Provider:
Date response received in HIM:	Amendment has been: ☐ **Accepted** ☐ **Denied**

If amendment denied, check reason for denial:

☐ PHI not created by this organization
☐ PHI is not available to the individual for inspection as permitted by federal law (e.g. psychotherapy notes)
☐ PHI is not part of designated record set
☐ PHI is accurate and complete

Signature of Healthcare Provider who created, reviewed, and responded to the amendment request:

Signature/Title: _____ Date: _____

Comments:

- Individual was informed of denial in writing (attach letter) Date letter sent: _____
  - Individual's Statement of Disagreement received (attach) ☐ Yes ☐ No
  - Letter of "Statement of Disagreement" (attach) ☐ Yes ☐ No

_____ _____

Signature/Title of HIM Staff Member Date