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AMENDMENT OF PROTECTED HEALTH INFORMATION

SECTION A: Patient to complete the following information

Date: _____

Patient Name: _____ Date of Birth_____

Address: _____

REQUEST:

I hereby request that the Facility amend the following in my Designated Record Set **(check all that apply)**:

_____My Medical Records _____ My Business Office Files

Date(s) of information to be amended (i.e., date of visit, treatment, or other health care services)

_____

The information is incorrect or incomplete in the following manner:

_____

_____

I request this amendment for the following reason(s):

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_____

_____

The information should be amended as follows:

_____

_____

I understand that the Facility may or may not supplement my record with an addendum based on my request. I also understand that the Facility is not able to alter the original documentation in a record under any circumstances. Regardless whether my request is granted or denied, I understand that this request will be made a part of my permanent Medical Record and will be sent as part of the Medical Record in response to any authorized requests for release of my Protected Health Information.

_____ _____

Signature of Patient or Legal Guardian Date

_____

Print Name

_____

Legal Guardian's Title (e.g., Guardian, Executor of Estate, Health Care Power of Attorney)

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AMENDMENT OF PROTECTED HEALTH INFORMATION - *side 2*

SECTION B: Facility to complete the following

Date of Receipt of Request _____

Request for correction / amendment has been: _____ Accepted _____ Denied

If denied, check reason for denial:

_____The PHI was not created by this Facility.

_____The PHI is not part of patients Designated Record Set.

_____The PHI is not available to the patient for inspection as required by federal law (i.e., psychotherapy notes)

_____The PHI is accurate and complete.

NOTICE TO PATIENT/OTHERS

Patient and/or others notified of determination via one or more of the following **(check all that apply)**:

_____*Amendment Acceptance Letter* sent to resident on _____ (date).

_____*Amendment Acceptance with Consent to Notify* sent to resident on _____ (date).

_____*Notification of Amendment* sent to identified persons pursuant to resident authorization on

_____ (date).

_____ _____

MD/NP Signature Date

_____

Print Name

Distribution of copies: Original to patient's Medical Record, copy to patient