| **Request for Amendment of Protected Health Information (PHI)** | MRN:<br>Name:<br>Date of birth: |
| --- | --- |

Address: ______________________________________________

Phone: ______________________________________________

What is your reason for making this request: ______________________________

______________________________________________

______________________________________________

Describe the document(s) you want amended. Please include all relevant dates. __________

______________________________________________

______________________________________________

______________________________________________

How do you believe the document should read? ______________________________

______________________________________________

______________________________________________

______________________________________________

Do you know of anyone who may have received or relied upon the information in question, such as your doctor, pharmacist or insurance company)? ☐ Yes ☐ No

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

______________________________________________

______________________________________________

______________________________ ______________________________

Signature of Patient or Personal Representative Date

______________________________ ______________________________

Printed name of Personal Representative Legal Authority of Personal Representative

Original to Medical Record
At your request we will provide you a copy of this form.

Health Information Services Approval: 2/10/2011

| Request for Amendment of Protected Health Information (PHI) | MRN:<br>Name:<br>Date of birth: |
|---|---|

FOR DEPARTMENT USE ONLY

**For Privacy Office**

☐ Request for Amendment is accepted.

☐ Request for Amendment is denied.

Check the reason for denial:

☐ Health Information was not created by this organization.

☐ Federal Law prohibits making the health information in question available to the patient for inspection.

☐ Information is not part of the designated record set.

☐ Originator of the record is not available because ______________________________

☐ Information is accurate and complete.

______________________________ ______________________________

Signature of Privacy Office Personnel Date

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**For Originator of Document:**

☐ Request for Amendment is accepted. I have amended the documentation in the medical record, electronic and/or paper.

☐ Request for Amendment is denied.

Check the reason for denial:

☐ Health information is accurate and complete as currently documented.

☐ Other: ______________________________

______________________________ ______________________________

Signature of Originator of Document Date

Original to Medical Record
At your request we will provide you a copy of this form.

Health Information Services Approval: 2/10/2011