Dartmouth-Hitchcock **Request for Amendment of Protected Health Information (PHI)**	MRN: Name: 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 Patient or Personal Representative Legal Authority of Personal Representative

At your request, we will provide a copy of this form.

Dartmouth-Hitchcock **Request for Amendment of Protected Health Information (PHI)**	MRN: Name: Date of Birth:

FOR INTERNAL USE ONLY:

To be Completed by Originator of Document:

☐ Request for Amendment is accepted. I have amended the documentation in the medical record as requested.

☐ Request for Amendment is accepted in part and denied in part.

I have agreed to amend the following: _____

_____

I have denied the request to amend the following (complete next section also): _____

_____

☐ Request for Amendment is denied in whole or in part. Check the reason for denial:

- ☐ Health information was not created by Dartmouth-Hitchcock.
- ☐ Information not part of the health information the patient is permitted to inspect, pursuant to Federal law, 45 CFR § 164.524.
- ☐ Information is not part of a designated record set maintained by or for Dartmouth-Hitchcock.
- ☐ Information is accurate and complete.

_____ _____

Signature of Originator of Document Date

_____

Printed Name of Originator of Document

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