Requests for Correction/Amendment of Health Information

You have the right to request an amendment to your protected health information. If you would like to request an amendment to your protected health information, please complete the form below and hand it to the Privacy Officer.

Patient Name: _____
Birth Date: _____

Patient Number: _____

Patient Address: _____
_____
_____

Date of amendment request: _____

Please explain how the entry is incorrect or incomplete. What should the entry say to be more accurate or complete?

_____
_____
_____

Would you like this amendment sent to anyone to whom we may have disclosed the information in the past? If so, please specify the name and address of the organization(s) or individual(s).

Name/Address:

_____
_____
_____
_____

Note: If you have additional names, please attach an additional sheet to this page.

I understand that by listing the name(s) and address(es) of other organizations on this Amendment form, I am asking _____ to disclose the requested amendment to these organizations. I therefore give specific permission to _____ to disclose the amendment to these organizations, and I understand that _____ will take reasonable steps to send the requested amendment to these organizations.

In addition, I understand _____ may be required to send this amendment to Business Associates or other organizations that _____ identifies as needing the amendment. I therefore give specific permission to _____ to send the

requested amendment to these organizations identified by _____ by _____ as needing the amendment.

I further understand that it is my responsibility to identify any originator(s) of my protected health information who may be no longer available to act on this amendment request, and present to _____ evidence that I have attempted to contact the originator(s). If I cannot present evidence of my attempts, _____ may deny the amendment request.

By signing below, I fully acknowledge and agree to the above terms.

_____

Signature of Patient

_____

Date