Request for Correction/Amendment of Health Information

Patient Name:_____ Date of Birth:_____/_____/_____
Patient Street Address_____ Patient Chart Number #_____
City/State/Zip_____
Phone Number_____

Type of entry to be amended:_____

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 or individual.

1._____ _____
Facility Name Address
2._____ _____
Facility Name Address

☐ Additional Facilities/Locations are attached.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Signature of Witness Date

For Healthcare Organization Use Only:

Date Received_____ Amendment has been: ☐ Approved ☐ Denied
If denied, check reason for denial: (PHI = Protected Health Information)

☐ PHI was not created by this organization
☐ PHI is not available to the patient for Inspection as required by federal law (e.g., psychotherapy notes)
☐ PHI is accurate and complete
☐ Documenting Employee is no longer affiliated with our facility

Comments of Healthcare Provider:

_____
_____

_____ _____
Name of Staff Member reviewing the amendment Title
_____ _____
Authorized Signature Date