Request for Amendment of Protected Health Information

PATIENT

Name (Last, First Middle)

Date of Birth

Record Number

THIS SECTION TO BE COMPLETED BY PATIENT

I request the following information be amended:

Dates of Entry(s) to be Amended:

Text of Entry(s) to be Amended:

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

Please indicate if you want an amended record sent to anyone whom we may have disclosed the information in the past. Specify name/address of the individual/organization:

Signature of individual or personal representative

(if representative, relation to patient)

Date

THIS SECTION TO BE COMPLETED BY ADMINISTRATOR ONLY

Note if entry is amended as requested:

- ☐ Paper
- ☐ Electronic
- ☐ Both

Specify electronic applications:

Notification of Determination sent to Patient/Requestor on date:

Notification of changes sent to entities that had received the information previously:

◯ Yes ◯ No

Comments:

Staff Member

Signature

Title

Date