# 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**