

PATIENT AMENDMENT REQUEST FORM

As a patient you have the right to request amendments to your protected health information. Protected health information includes medical records, physician's notes, images, laboratory results, etc.

Today's Date:

Patient Name:

Medical Record #:

Birth Date:

Patient Address:

Description of information to be amended: *(e.g. medical record, lab results)*

Date(s) of the information to be amended: *(date of office visit, date of procedure, date of other services)*

What is the reason for requesting amendments? *(e.g. outdated, incomplete, or incorrect)*

What are the requested amendments?

Do you know of anyone who may have received or relied on the information in question?
(e.g. doctor, health plan, or other health care provider)

Yes _____ No _____

If yes, who?

Signature of patient or legal representative:

Date:

FOR INTERNAL USE ONLY

Amendment has been: Accepted _____ Denied _____

If denied, the reason for denial

- PHI was not created by the organization
- PHI is part of the patient's designated record set
- Federal law forbids making the PHI in question available to the patient for inspection
- PHI is accurate and complete

Comments:

Signature of staff person:

Date:

Print Name and Title: