Request to Correct or Amend Protected Health Information

Patient name: _____ **Date of birth:** _____

Previous name: _____

Patient mailing address: _____

❒ I request a change to my records.

Please explain what the information in your record should say to be more accurate or complete. If you need additional space, please include a separate page. **Date of entry in record:** _____

_____

_____

_____

Patient's or legally authorized individual's signature **Date**

_____

Relationship to patient if signed on patient's behalf (parent, legal guardian, personal representative)

We will review your request and respond within ten (10) days of receiving your request. A copy of your request will be added to your record. If we grant your request, we will send changes to anyone you identify and to anyone who received the information in the past and who needs to know about the change.

To be completed by the practice/health care facility:

Date received: _____ **Correction/Amendment has been:** ❒ accepted ❒ denied

❒ The review of this request for correction/amendment has been delayed.

Your request will be processed
by the following date: _____ (not later than 21 days after the request).

If denied, check reason for denial:

❒ The existing health information is accurate and complete.
❒ This request does not pertain to the patient's medical and financial records.
❒ Due to federal and state laws, this health information is not available and therefore cannot be amended or corrected.
❒ This health information was not created by this organization.
❒ The record no longer exists or cannot be found.
❒ The record is not maintained by this organization.