Attachment A to Policy 07-02-01.3
Request for Amendments to Protected Health Information Policy
SAMPLE FORM
REQUEST TO CORRECT/AMEND PROTECTED HEALTH INFORMATION

Individual's Name: _____

Address: _____

SS# (last 4 digits): _____

DOB: _____

Originating Component: _____

Date of Entry to be amended: _____

Document(s) to be amended (discharge summary, progress note, etc.):

_____

_____

Reason for requesting the amendment?

_____

_____

_____

What changes should be made to the record?

_____

_____

_____

_____

If appropriate, please list any organizations or individuals, along with their addresses, who may have received the information in the past. Should your request for amendment be approved, the amendment will be forwarded to them.

Name Address

_____

_____

_____ _____

Signature of Patient or Legal Representative Date

For Component Use Only

Date Request Received: _____

Amendment has been:

_____ Accepted — If accepted, an amendment will be made to the appropriate protected health information.

_____ Denied — Reason for denial specified below. If denied, check reason for denial:

_____ The protected health information or record was not created by this organization.

_____ The protected health information or record is not part of the patient's “designated record set."

_____ The protected health information or record is not available to the patient for inspection as required by federal law (e.g., psychotherapy notes.)

_____ The protected health information or record is accurate and complete.

Comments: _____

_____

_____

Individual Processing Form Title Date

_____

Signature of Authorized Component Employee Date

_____