

**Request for Amendment/Correction of Protected Health Information**

Name: \_\_\_\_\_ Requested date: \_\_\_\_\_  
 Street address: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
 City/State/Zip: \_\_\_\_\_ MR/Account #: \_\_\_\_\_

**What Needs to be Amended/Corrected and Why**

Entry to be amended: \_\_\_\_\_

Date and author of entry: \_\_\_\_\_

Please explain how the information is incorrect or incomplete. What should the information state to be more accurate or complete? \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

If this amendment is accepted, would you like this amendment sent to anyone whom we may have disclosed this information in the past? If so, please specify the name and address of the organization or individual.

Names and addresses: \_\_\_\_\_  
 \_\_\_\_\_

I understand that the provider may or may not amend the medical record with an amendment based on my request, and under no circumstances is the provider permitted to alter the original medical record. In any event, this request for an amendment will be made part of my permanent medical record.

\_\_\_\_\_  
 Signature of Patient or Patient's Legal Representative Date

**For Healthcare Organization/Internal Use Only**

Date received: \_\_\_\_\_  Accepted  Denied

If denied, check reason for denial:

- PHI was not created by this organization
- PHI is not part of the designated record set
- PHI is not available to the individual for inspection as permitted by federal law (e.g., psychotherapy notes)
- PHI is accurate and complete

Comments: \_\_\_\_\_  
 \_\_\_\_\_

Individual was informed of denial in writing (attach letter)  Yes  No  
 Individual's Statement of Disagreement received (attach)  Yes  No  
 Letter of Statement of Disagreement Review (attach)  Yes  No

\_\_\_\_\_  
 Signature/Title of staff member Date