CAROLINAEAST
MEDICAL CENTER
New Bern, NC

REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION

PATIENT IDENTIFICATION:

Patient Name: _____

Date of Birth: _____Medical Record #_____
(if known)

Address: _____ Phone: (H) _____

City/State/Zip: _____ Phone: (W) _____

STATEMENT OF REQUESTED AMENDMENT:
State your request for amendment of protected health information that you want CarolinaEast Medical Center to make. **Note specifically what you want amended and the report where it is documented.**

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State your reason(s) for your request for amendment of protected health information.

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_____

PERSONS TO RECEIVE NOTICE:
Provide the name, address, telephone number and e-mail address for any person or entity that you are aware has received this protected health information and whom you agree should be informed of any amendment.

_____

_____

_____

AUTHORIZATION:
By signing this form, I agree to CarolinaEast Medical Center disclosing any accepted amendment of my protected health information to the persons or entities that I have identified above and to the persons or entities that CarolinaEast Medical Center knows have received this protected health information and may have relied upon the information to the patient's detriment.

If you sign as the legal representative, your signature is a certification to CarolinaEast Medical Center that you have legal authority to act for the patient. You may also be asked to provide documentation that you are the patient's legal representative.

Signature of Patient/Legal Representative: _____

Date: _____ Relationship to Patient if other than patient: _____

If you are the legal representative, include the following:

Address: _____ Phone: (H) _____

City/State/Zip: _____ Phone: (W) _____

Return this completed form to:

Health Information Services Director
CarolinaEast Medical Center
2000 Neuse Boulevard
P.O. Box 12157
New Bern, NC 28561
252-633-8794