

Request To Amend Protected Health Information

I understand that I have the right to request amendment to incorrect or incomplete protected health information subject to some limitations. I understand Lake Regional Health System (LRHS) shall respond to my request for amendment in fewer than 60 days from the date of my request. LRHS may deny my request to amend my protected health information but I have the right to appeal the denial.

Patient Name: _____ Request Date: _____

Address: _____ Telephone: _____

1. Identify the specific item (s) in the record that you would like to be changed (amended).

For Healthcare Organization Use Only:

Licensed Reviewer: _____ Date: _____

Request Denied Approved as Requested Approved Per Comments (Document below)

If denied, check reason for denial:

- PHI not created by this organization
- PHI is not part of the patient's designated record set
- PHI is accurate and complete
- PHI is not available to the patient for inspection as required by state and/or federal law (e.g. psychotherapy notes)

Comments: _____

Medical Records Signature: _____ Review Date: _____

Approved: Yes ___ No ___

Patient Informed in Writing (Patient Notification of Amendment): Yes ___

Notification Date: _____