PATIENT REQUEST TO AMEND PROTECTED HEALTH INFORMATION

Patient Name____ Birthdate:________________ MR#_____________

Address:____

Home Phone:___________________________ Work Phone:____________________________________

Please explain what you believe is incorrect or incomplete in your record___________________________

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Specify amendment you would like to have made in your record___________________________________

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Signature of Patient Or Representative____ Authority or Relationship To Patient________________________

Date Signed____

Date Received_________________________ Amendment has been: Accepted [ ] Denied [ ]

If denied, the reason for denial is:
[ ] Protected Health nformation was not created by this organization
[ ] Protected Health Information is not part of the patient's designated record set.
[ ] Protected Health Information is accurate and complete.
[ ] Protected Health Information is not available to the patient for inspection are required by Federal Law. (e.g. psychotherapy notes).

____ _______________________________
Signature of Healthcare Practitioner Date

____ _______________________________
Signature of Privacy Officer Date

Reviewed 6/2012

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Powell Valley Hospice Express Care The Heartland Practice Management Associates