Request to Correct/Amend Protected Health Information Form

Patient Name:	Middle or Other Name:	Patient Date of Birth:
Patient Street Address:		Patient Apt/Unit/Suite:
Patient City:	Patient State:	Patient Zip Code:
Patient Telephone: ☐Mobile or ☐Home	Patient Fax Number (if applicable):	Patient Email Address:

Date of Entry to be Amended: _____ Provider(s) Seen:

Explain how the entry is incorrect or incomplete> (Use additional paper if more room is needed to explain.)

Would you like this amendment sent to anyone to whom we may have disclosed the information in the past? If so, the name and address of the organization or individual:

Recipient Name and Address_____

Signature of Patient or Legal Representative_____ Date_____

For Organization Use Only:

Date Received by HIM:

Accepted: ☐ An amendment will be made to the appropriate protected health information
Denied: ☐Reason for denial specified below, Check reason for denial:
- ☐PHI was not created by this organization
- ☐PHI is not part of patient's designated record set
- ☐PHI is accurate and complete
- ☐PHI is not available to the patient for inspection as required by federal (e.g. psychotherapy notes)

Comments of Healthcare Provider:

MRN #: _____ Account #: _____

Signature of Healthcare Provider: _____ Date: _____