



## Request for Correction/Amendment of Health Information

\_\_\_\_\_  
Patient Name (Print)

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Patient Address

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Date of entry to be amended

\_\_\_\_\_  
Type of entry to be amended

Please explain how the entry is incorrect or incomplete. What should the entry say to be more accurate or complete?

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

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

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

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

If representative, print name and state relationship: \_\_\_\_\_

**For Healthcare Organization Use Only:**

MR #: \_\_\_\_\_

Admit #: \_\_\_\_\_

Date Received: \_\_\_\_\_

Amendment has been: Accepted

Declined

If declined, check reason for denial:

PHI was not created by this organization

PHI is accurate and complete

Other, please specify: \_\_\_\_\_

\_\_\_\_\_  
Signature of Healthcare Practitioner

\_\_\_\_\_  
Date