REQUEST FOR CORRECTION/AMENDMENT OF PROTECTED HEALTH INFORMATION

_____

PRINT PATIENT NAME DATE OF BIRTH SOCIAL SECURITY #

PATIENT ADDRESS: _____

(STREET) (CITY) (STATE) (ZIP CODE)

PATIENT TELEPHONE # : _____

DATE OF ADMISSION OR TREATMENT: _____

DATE AND TIME OF ENTRY TO BE AMENDED: _____

TYPE OF RECORD TO BE AMENDED (check appropriate box)

☐ 1. ADMISSION / REGISTRATION DATA	☐ 4. DISCHARGE SUMMARY	☐ 7. NURSES NOTES
☐ 2. HISTORY and PHYSICAL	☐ 5. PHYSICIAN ORDER	☐ 8. LABS
☐ 3. OPERATIVE NOTE	☐ 6. PHYSICIAN PROGRESS NOTE	☐ 9. OTHER

PLEASE EXPLAIN HOW THE ENTRY IS INCORRECT OR INCOMPLETE: _____

WHAT DO YOU BELIEVE THE ENTRY SHOULD BE : _____

Please identify any persons who have received the protected health information about you who need the amendment(s), if accepted:

_____

NAME STREET CITY STATE ZIPCODE

_____

NAME STREET CITY STATE ZIPCODE

_____

NAME STREET CITY STATE ZIPCODE

_____ _____

SIGNATURE OF PATIENT DATE

_____ _____

PRINTED NAME OF PATIENT REPRESENTATIVE RELATIONSHIP TO PATIENT