REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION (PHI)

Print Patient Name | Date of Birth | Last 4 digits of Social Security Number

Patient Address: Street | City | State | Zip Code

Patient Telephone Number: _____

Date of Admission(s) or Treatment: _____

Date and time of entry to be amended: _____

Description of PHI to be amended (include specific documents and dates of service): _____

_____

_____

Please explain how the entry is incorrect or incomplete: _____

_____

_____

What do you believe the entry should be: _____

_____

_____

Attach additional sheet if necessary.

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

_____
Name Street City State Zip Code

_____
Name Street City State Zip Code

_____
Name Street City State Zip Code

_____ _____
Signature of Patient or Patient's Legal Representative Date

_____ _____
Printed name of Patient or Patient's Representative Relationship to Patient

REVISION DATE: 11/18/2014

This Section for BSWH System Use Only

MRN: _____ Patient Name: _____

Date (s) of Documents: _____

Date request received: _____

Deadline to grant/deny requested amendment:_____

Extension requested? _____ no _____yes. If yes, reason:_____

Date Individual notified in writing of extension: _____

New deadline:_____

Amendment: Granted _____ Denied _____

Date Individual notified: _____

Date amendment documents Scanned into EMR: _____

If granted, date records were appended or linked to the amendment:_____

If denied, date the statement of disagreement was received (if any): _____

BSWH rebuttal to statement of disagreement prepared? Yes _____ No _____

Date rebuttal sent to individual: _____

Records appended or otherwise linked to (check when complete): request for amendment _____ denial of the request _____ statement of disagreement _____ rebuttal _____

Name and title of staff member processing request: _____