# REQUEST AMENDMENT TO PHI

**Name** ______________________________________________
(Last) (First) (M.I.)

**Address** ______________________________________________ **Date** ____________

______________________________________________ **Telephone #** ____________
(City) (State) (Zip)

**Date of Birth** ______________________ **Social Security #** ______________________
(OPTIONAL)

Please tell us what protected health information you want to change: ______________________

Please tell us why you want to make this amendment to your health record (in 250 words or less):

We must tell you within 60 days if we will change your protected health information as you requested, or tell you that we need more time (Up to 30 additional days) to decide.

Please tell us where to send you a letter if different from above:

Address: ______________________________________________

Available hours to inspect your protected health information are Monday through Friday, 8:00 a.m. to 5:00 p.m.
*There will be reasonable clerical fees charged for any inspection of the designated record set as authorized by STATE Law and posted in the Health Information Management Department (medical records).

If we decide to change the health information as you requested, we will send the change, upon request, to any person who received the information before it was changed. Please tell us if there are any such persons who need the changed information:

Yes. Please list names and addresses: ______________________
No. Initials: ________

We do not have to change your protected health information if:

1. We did not create the information, unless the person who created the information is unavailable to act on your request to change it (for example, the doctor who originally created the information has died). If this exception applies to you, please explain:
2. The information is accurate and complete.
3. You do not have the legal right to access the protected health information you want changed.
4. The protected health information you want changed is not part of the designated record set. This includes your medical records; billing records and records containing your protected health information that are used by us to make decisions about you.

Date: ______________________
Signature of Patient or Legal Representative: ______________________
If Legal Representative, state relationship: ______________________

For more information about your privacy rights, see the “Notice of Privacy Practices” available on our website at XXXXXX.

**THIS SECTION WILL BE COMPLETED BY THE REVIEWER**

Date Received ______________________ Reviewed by: ______________________
Last) (First) (M.I.)

Healthcare Representative Signature______________________ Date: ____________

Telephone consent requires two witnesses:

1) ______________________ 2) ______________________
Name/Title/Date Name/Title/Date