REQUEST FOR AMENDMENT OF HEALTH INFORMATION

Please complete the following information:

1. Today's date: _____
2. Patient Full Legal Name:_____
3. Birth date:_____ Patient Phone Number:_____
4. Patient #: _____ (Facility use only)
5. Patient street address:_____
   City: _____ State: _____ Zip: _____
6. Describe the information you want amended (e.g., lab test results, physician notes)
   _____
7. Date(s) of information to be amended (e.g., date of office visit, treatment, or other health care services)
   _____
8. What is your reason for making this request? _____
   _____
9. How is the entry incorrect or incomplete? _____
   _____
10. **Please attach written amendment.**
11. Do you know of anyone who may have received or relied on the information in question (such as your doctor, pharmacist, health plan, or other health care provider)?
    If yes, please specify the name(s) and address(es) of the organization(s) or individual(s).
    _____
    _____
12. If the amendment is accepted, do we have your permission to share the amendment with individuals who have received this information? _____

_____	_____	_____
Date	Patient/Authorized Representative	Relationship to Patient

FOR HEALTHCARE ORGANIZATION USE ONLY

Amendment has been: ☐ Accepted ☐ Denied

Signature of Facility Privacy Official: _____ Date: _____ Time:_____

- ☐ Patient has <u>not</u> filed a Statement of Disagreement, but requests that any future releases include the requested amendment and denial information.
- ☐ Patient has filed a Statement of Disagreement that must be released along with other documentation with any future releases of information.
- ☐ Facility/provider appended written response (rebuttal) and forwarded to patient.
- ☐ Facility/provider did not provide a response/rebuttal.

Request For Amendment Of Health Information

Patient Information/Label

DIS
50021 (09/13)