St. Elizabeth PHYSICIANS

Request to Amend Protected Health Information

Please fill in the following information:

Your Name: _____

Your Mailing Address: _____ City _____St. ____ Zip_____

Patient Name (if different) _____ Patient Birth Date_____

If you are not the patient, your relationship to the patient: _____

Describe the information you feel is incorrect or incomplete: _____

_____.

Dates of the information you want to amend: _____

What is the reason for this request? _____

_____.

How is the current information incorrect or incomplete? _____

_____.

What should the entry say to be more correct or complete? _____

_____.

Do you know of anyone who may have received or relied on the information you want to amend (such as another doctor, pharmacist, or health plan)? __ Yes __ No If yes, please give the name(s) and address(s) of the organization(s) or individual(s) _____

_____.

Do you specifically authorize us to notify the person(s) listed above and any other persons or entities with whom we may have shared the information to be amended, of any amendment that is made to your health information as a result of this request? __ Yes __ No

Signature of patient or legal representative _____ Date _____

Submit this request to the office manager of the office where the patient has been seen. You will receive a written response from us within 60 calendar days of our receipt of your request. In very few circumstances, we may need an additional 30 days to respond to a request for amendment beyond the 60 day period. If that happens in your case, we will send you a written notice before the 60 days expire to inform you that we will need an additional 30 days to respond. If your request for amendment is denied, you will receive a written reason for the denial and we will explain your rights to have the denial decision reviewed and/or your right to submit a written statement of disagreement that can be included in future disclosures of the unamended information.