



**REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION (PHI)**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Address: \_\_\_\_\_ Date: \_\_\_\_\_

**Section A: Patient (or Legal Representative) to complete the following information:**

I hereby request that The Care Team amend the following information in my Designated Record Set:

- My clinical records       My business office files

Dates of information to be amended (i.e., date of visit, treatment, or other health care services):

\_\_\_\_\_

I request this amendment for the following reason(s): \_\_\_\_\_

\_\_\_\_\_

The information should be amended as follows (please include attachment if necessary): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If the request for amendment is made as described above, would you like the amended information sent to anyone else who has received the information in the past?  Yes  No If yes, please specify the name and address of the organization(s) or individual(s): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I understand that The Care Team may or may not supplement my record with an addendum based on my request. I also understand that The Care Team is not able to alter the original documentation in a record under any circumstances. Regardless of whether my request is granted or denied, I understand that this request will be made a part of my permanent Medical Record and will be sent as part of the Medical Record in response to any authorized requests for release of my Protected Health Information (PHI)

Signature of Patient/Legal Representative: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

Legal Representative Relationship to patient: \_\_\_\_\_



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**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Patient Address:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Section B: For The Care Team Use Only:**

Date Request Received: \_\_\_\_\_

Request for correction/amendment has been:  Accepted  Denied

If denied, indicate the reason:

- The PHI was not created by The Care Team
- The PHI is not part of Individual's designated record set
- The PHI is not available to the Individual for inspection as required by Federal law
- The Phi on file is accurate and complete

**Notice to Individual/Others**

Individual and/or others notified of determination via one or more of the following (check all that apply):

- Amendment Acceptance Letter sent to Individual on this date: \_\_\_\_\_
- Amendment Acceptance with Consent to Notify sent to Individual on this date: \_\_\_\_\_
- Notification of Amendment sent to identified persons pursuant to Individual's authorization on this date: \_\_\_\_\_
- Amendment Denial Letter sent to Individual on this date: \_\_\_\_\_

Signature of Medical Director or Designee: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Comments of the Healthcare Provider/Medical Director (if applicable): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of Healthcare Provider/Medical Director (if applicable): \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name/Title: \_\_\_\_\_

*Distribution of copies: Original to Individual's record, copy to Individual*