TRI-CITIES COMMUNITY HEALTH

PATIENT AMENDMENT REQUEST FORM

As a patient you have the right to request amendment to your protected health information. Protected health information includes medical records, physician's notes, images, laboratory results, etc.

Today's Date: _____ Medical Record #: _____

Patient Name: _____

Birth Date: _____

Patient Address: _____

Description of the information to be amended: (e.g. medical record, lab results)

Date(s) of the information to be amended: (date of office visit, date of procedure, data of other services)

What is the reason for requesting amendment(s)? (e.g. outdated, incomplete, or incorrect)

What are the requested amendments?

Do you know of anyone who may have received or relied on the information in question? (e.g. doctor, health plan, or other health care provider) Yes___ No___
If yes, who? _____

Signature of patient or legal representative: _____ Date: _____

FOR INTERNAL USE ONLY

Amendment has been: Accepted ____ Denied _____

If denied, the reason for denial

☐ PHI was not created by the organization

☐ PHI is part of the patient's designated record set

☐ Federal law forbids making the PHI in question available to the patient for inspection

☐ PHI is accurate and complete

Comments: _____

Signature of staff: _____ Date: _____

Print Name and Title: _____