A Service of Dignity Health Medical Foundation
Mercy Medical Group

Health Information Management
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Exhibit A

INDIVIDUAL'S REQUEST FOR AMENDMENT OF PHI

Patient Name:_____
Date of Birth: _____MR# or Account #: _____

Date of entry or description of information to be amended: _____

Please attach copy of the record entries highlighting the entries you are requesting to be amended.

Please explain how the entry is incorrect or incomplete. What should the entry say to be more accurate or complete? _____

_____

_____

_____

Please indicate the reason why you want this change. This must be provided.

_____

Would you like this amendment sent to anyone to whom we may have disclosed the information in the past? ☐ No ☐ Yes If so, please provide their name(s) and address (es):

_____

Name Address

_____

Name Address

I understand that my request may be denied if:

1. The original information is accurate and complete
2. The hospital or facility did not create the information.
3. I do not have legal right to access the health information I want to change.
4. The protected health information I want changed is not part of the designated record set. This includes my medical record, billing records and records containing my health information used to make decisions about me.

I understand that I will receive notification within 60 days of the decision of my request, or will be notified if more time (up to 30 days) is needed.

_____ _____

Name of Patient or Legal Representative Signature of Patient of Legal Representative

_____

Address, City and Zip

_____ _____

Date Phone

****

Approved / Denied (circle one) By;

Name: _____ Title:_____ Date:_____ Date Notification sent:_____

Patient/Representative Identification Verified: Yes ___ No ___

Revised: 09/17/2019