ROGERS
Behavioral Health

# REQUEST FOR AMENDMENT/CORRECTION OF PROTECTED HEALTH INFORMATION

| PATIENT INFORMATION | | | |
|---|---|---|---|
| Patient Name: | | Request Date: | |
| Street Address: | | Date of Birth: | |
| City/State/Zip: | | MRN / FIN: | |

**WHAT NEEDS TO BE AMENDED/CORRECTED & WHY**

| | |
|---|---|
| Entry to be amended: | |
| Date & Author of entry: | |

Please explain how the information is incorrect or incomplete. What should the information state to be more accurate or complete?

Would you like this amendment sent to anyone to whom we may have disclosed this information in the past? If so, please specify the name and address of the organization or individual.

Names & Addresses:

I understand that the provider may or may not amend the medical record with an amendment based on my request, and under no circumstances is the provider permitted to alter the original medical record. In any event, this request for an amendment will be made part of my permanent medical record.

_____ _____
Signature of Patient or Patient's Legal Representative Date

**FOR HEALTHCARE ORGANIZATION/INTERNAL USE ONLY**

| | | |
|---|---|---|
| Date received: | ❑ Accepted | ❑ Denied |

If denied, check reason for denial:

- ❑ Personal Health Information was not created by this organization
- ❑ Personal Health Information is not available to the patient for inspection as permitted by federal law (e.g., psychotherapy notes)
- ❑ Personal Health Information is not part of patient's designated record set
- ❑ Personal Health Information is accurate and complete

Comments:

- ❑ Individual was informed of denial in writing (attach letter of communication)

_____ _____
Signature and Title of Staff Member Date