Premier Health

Premier Health Information Management Facility List: 28424

AMENDMENT REQUEST FORM

Patient Name: _____
Patient Date of Birth: _____
Name of Person Requesting Amendment:
_____

HIM Use Only
MRN#:
ACCT#: ***

Address to Receive Notice:
_____
_____

Patient address:
_____
_____

Telephone Number:_____

You have the right to request corrections or amendments to Personal Health Information we retain on your behalf if you believe something in that information is in error or needs to be amended. We are not always required to make the corrections or amendments you request but each request will be carefully reviewed and corrections or amendments made if warranted. You will be notified when your request has been approved or denied. Please provide as much detail as possible regarding the record type, the location, the date and the problem. For instance, "My laboratory test results from ABC laboratory of December 5, 2000 show a blood test I never received" or "Dr. Jones in your North Street Clinic recorded in my record on December 5th, 2000 that I was suffering from weakness in my right leg when in fact the weakness was in my left leg" In order to review the requested correction, we must be able to locate the record in issue and the exact entries or reports you want corrected.

_____
_____
_____
_____
_____

Please state as precisely as possible how you would like to see the record worded.

_____
_____
_____
_____

If you are aware of any of your healthcare providers who may have a copy of the record you seek to have corrected, please list those persons or facilities here with as much information as you have available regarding names and addresses.

Name: _____
Address: _____
City: _____State: ____ Zip_____
Date: _____

Name:_____
Address:_____
City: _____ State: ____Zip_____
Date: _____

I hereby authorize the indicated organization listed above to notify the persons/entities I have listed above that may have a copy of the record I seek to have corrected and to provided them with the amended information.

(cont'd next page)

Signature:_____ Date:_____

Note that no Amendment Request will be processed unless the patient or patient representative has signed this form

If patient representative is completing this form, provide documentation or explanation of your authority to act for the patient:_____