



REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION (PHI)

Print Patient Name _____ Date of Birth _____ Last 4 digits of Social Security Number _____

Patient Address: _____
Street City State Zip Code

Patient Telephone Number: _____

Date of Admission(s) or Treatment: _____

Date and time of entry to be amended: _____

Description of PHI to be amended (include specific documents and dates of service): _____

Please explain how the entry is incorrect or incomplete: _____

What do you believe the entry should be: _____

Attach additional sheet if necessary.

Please identify any persons who have received the protected information about you and who need the amendment(s), if granted:

Name Street City State Zip Code

Name Street City State Zip Code

Name Street City State Zip Code

Signature of Patient or Patient's Legal Representative

Date

Printed name of Patient or Patient's Representative

Relationship to Patient

This Section for BSWH System Use Only

MRN: _____ Patient Name: _____

Date (s) of Documents: _____

Date request received: _____

Deadline to grant/deny requested amendment: _____

Extension requested? _____ no _____ yes. If yes, reason: _____

Date Individual notified in writing of extension: _____

New deadline: _____

Amendment: Granted _____ Denied _____

Date Individual notified: _____

Date amendment documents Scanned into EMR: _____

If granted, date records were appended or linked to the amendment: _____

If denied, date the statement of disagreement was received (if any): _____

BSWH rebuttal to statement of disagreement prepared? Yes _____ No _____

Date rebuttal sent to individual: _____

Records appended or otherwise linked to (check when complete): request for amendment _____
denial of the request _____ statement of disagreement _____ rebuttal _____

Name and title of staff member processing request: _____