Dignity Health.
St. Rose Dominican

REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION

Patient's Name: _____
Last First Middle

Home Address: _____

_____

Telephone Phone: _____

Date of Birth: Date of Request: _____

I hereby request an amendment to the following: **[please check all boxes that apply]**:

- ☐ My medical records.
- ☐ My billing records.
- ☐ My enrollment, payment, claims adjudication, case or medical management records.
- ☐ My records used by or to make decisions about me.
- ☐ All as more specifically described below

_____
_____
_____
_____

I understand that Dignity Health – St. Rose Dominican Neighborhood Hospital (the Hospital) may deny this request as permitted under federal law. I further understand that if the Hospital denies my request, I will be informed in writing by the Hospital of its reason for the denial and what I should do if I disagree with the denial. I further understand that the Hospital will notify me of its decision to accept or deny my request within sixty (60) days of receiving this request. If the Hospital is unable to comply with my request within this time frame, I understand that it may extend the applicable deadline for up to an additional thirty (30) days) by notifying me in writing. I further understand that this request and any decision regarding this request will be included in my medical record.

1. Describe the information you want amended (e.g., procedures, nursing/physician notes, test results):

   _____
   _____
   _____
   _____

2. Date(s) of information to be amended (e.g., date of office visit, treatment, or other health care services) ___/___/_____; ___/___/_____; ___/___/_____; ___/___/_____; ___/___/_____; ___/___/_____

3. What is your reason for making this request?

   _____
   _____
   _____
   _____

4. How is the entry incorrect, incomplete, or outdated?

   _____
   _____
   _____

5. What should the entry say to be more accurate or complete (Please be as specific as possible)?

   _____
   _____
   _____

6. Do you know of anyone who may have received or relied on the information in questions (such as your doctor, pharmacist, health plan, or other health care provider)?

   ☐ Yes
   ☐ No

   If yes, please specify the name(s) and address(es) of the organization(s) of individual(s):

   _____
   _____
   _____

Signature of Patient or Patient's Personal Representative

_____

Date ___/___/____

For Internal Use Only: The identity of the requestor has been validated either with a government issued picture ID, such as a driver's license or passport, or comparison of signatures documented in the PHI records.

_____
Signature of employee validating identity

Amendment has been: ☐ Accepted ☐ Denied
If denied, check the reason for denial:
☐ PHI was not created by the Hospital
☐ PHI is not part of the Patient's Designated Record Set
☐ PHI is not accessible by the Patient under the Hospital 's policy regarding the Patient's right to access his or her Protected Health Information
☐ PHI is accurate and complete

Comments:

_____
_____
_____

Signature of Reviewer: _____
Title of Reviewer: _____
Date: ___/___/____