Health Information Compliance Alert

Clip And Save Tool: Adapt This Form For Your PHI Amendments

When a patient wants a PHI correction, pull out this handy document.

Direct from the **Oregon Association of Hospitals and Health Systems** to your doorstep, here's a sample document your patients can use to request amendments to their protected health information and for your organization to respond to such requests.

Remember: Covered entities must respond to PHI amendment requests within 60 days of their receipt.

REQUEST FOR AMENDMENT OF THE MEDICAL RECORD

[NAME OF ENTITY]

Patient Name: _____ Date of Birth: _____ Address:_____ Phone Number: _____

After review of my medical record, I do not feel that the original documentation made by _____ accurately reflects my treatment, condition, or diagnosis on the following date _____ and should be supplemented with clarifying information in the form of an addendum to my medical record.

I understand that my physician or health care provider may or may not supplement my record with an addendum based on my request. I understand that my physician or other health care provider is not allowed to alter the original documentation in my record. I understand that my request for amendment will be made a permanent part of my medical record and will be sent with any future authorized medical record request for information.

I understand that [NAME OF ENTITY] will provide a response to this request within sixty days. I understand I have the opportunity to provide a statement of disagreement should my physician or health care provider deny my request.

Reason for amendment: _____
_____

I request the following correction/amendment be made on my medical record: _____
_____

Signature: _____ Date: _____

PHYSICIAN OR HEALTH CARE PROVIDER RESPONSE

In response to your request, a correction/amendment will be made part of your permanent medical record.

Your request has been denied; however, your request is made part of your permanent medical record. The reason your request is denied: _____
_____

Signature: _____ Date: _____

Date response sent to patient: _____

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