REQUEST FOR AMENDMENT/CORRECTION OF PROTECTED HEALTH INFORMATION

Amendment - SCAN, REQUEST FOR AMENDMENT, 8/29/23

Patient Name: ______________________________ Date: ______________

Street Address: ______________________________

City: ______________________________ State: __________ Zip Code: ______________

Important Information: *As provided for under the Health Insurance Portability and Accountability Act (HIPAA) and federal regulations, patients have the right to request an amendment or correction to their protected health information. Requests will be acted on by Catholic Health within the timeframe(s) permitted under the law. Your request for amendment will either be accepted or denied. If denied (whole or in part), you will be provided with the reasons for denial and provided with an opportunity to provide a statement of disagreement.*

Please indicate, specifically, what health information you wish to have amended or corrected and what your information should say or reflect to be more accurate or complete. Please also indicate the reasons for requesting such amendment. You may attach a separate sheet if necessary.

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*If possible, please identify source/location of the information in the medical record to be amended.

If accepted, please provide the name(s) of the individual(s) or organization(s), their address and telephone number, of those who you wish to share your amendment with:

1. ______________________________
2. ______________________________
3. ______________________________

Patient or Personal Representative Name:

______________________________ ______________________________

Print Signature

If Personal Representative, please complete the information below:

______________________________ ______________________________

Relationship to Patient Contact Information (if different from above)

FOR CATHOLIC HEALTH USE ONLY

Date Request Received: ______________________ MRN: ______________________

Name of Workforce Member Processing: ______________________ Facility/Entity: ______________

Request Status: ___ Accepted ___ Denied *Provide Response Form to Patient/Patient Representative*

Date of Request Status: ______________________ CSN: ______________________

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