Harney District Hospital

PATIENT REQUEST TO AMEND PROTECTED HEALTH INFORMTION (PHI)

Patient Name_____ Date of Birth_____

Patient Address_____ Phone # _____

_____

DATE(S) OF ENTRY TO BE CORRECTED/AMENDED:

_____

INFORMATION TO BE CORRECTED/AMENDED:

☐ my medical records ☐ my billing records

☐ my records used by HDH to make decisions about me

☐ all of the above

PLEASE EXPLAIN HOW THE ENTRY IS INCORRECT OR INCOMPLETE. WHAT SHOULD THE ENTRY SAY TO BE MORE ACCURATE OR COMPLETE? USE BACK OF FORM OR ADDITIONAL SHEETS IF NEEDED AND ATTACH TO THIS FORM.

_____

_____

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_____

INITIAL

_____ I understand that HDH may deny this request as permitted under Federal law and that I will be informed by HDH concerning the basis for the denial along with instructions concerning right to submit a statement disagreeing with such denial. I further understand that HDH will notify me of its decision to accept or deny my request within 60 days of receiving this request. If HDH is unable to comply with my request within this timeframe, I understand that HDH may extend the applicable deadline for up to an additional 30 days by notifying me in writing.

_____ _____

Signature of Patient (or Personal Representative) Date

_____ _____

Printed Name of Personal Representative Relationship to Patient

FOR HDH USE ONLY

_____

Date Received

AMENDMENT HAS BEEN:

☐ ACCEPTED ☐ DENIED

_____ _____

Signature of Healthcare Provider *(if applicable)* Date

_____ _____

Signature of HIM Director Date

IF DENIED, REASON FOR DENIAL:

☐ PHI IS NOT PART OF THE PATIENT'S DESIGNATED RECORD SET

☐ HDH DID NOT CREATE THE RECORD

☐ RECORD IS ACCURATE AND COMPLETE

COMMENTS: