



Request for Amendment of Protected Health Information

Patient Name: _____ DOB: _____

Medical Record #: _____ Phone Number: _____

Patient Address: _____

Date(s) of entry to be amended: _____

Type of entry(s) to be amended: _____

Please explain how the entry is incorrect or incomplete. What should the entry say to be more accurate or complete? _____

Would you like the amendment sent to anyone whom we may have disclosed information prior to your amendment request? If so, please provide the name and address of the organization or individual.

_____	_____
Name	Address

_____	_____
Signature of Patient or Personal Representative	Date

Authority to sign if not the Patient

For Mercy Health Use Only:

Date Received: _____ Received by: _____ Amendment: Accepted Denied

If denied, check reason for denial:

- PHI was not created by Mercy Health
- PHI is not a part of patient's Designated Record Set
- PHI is not available to the patient for inspection as required by Federal Law (e.g. Psychotherapy Notes)
- PHI is accurate and complete

Comments of Health Care Practitioner (Clinician-author): _____

_____	_____
Name of Health Care Practitioner	Title

_____	_____
Signature of Health Care Practitioner	Date/Time