REQUEST FOR AMENDMENT OF HEALTH INFORMATION

I request that HENDRICKS REGIONAL HEALTH amend certain information contained in my medical or billing record. I am providing a written detailed description of the requested amendment and the reasons for this request in the space below.

Patient Name:
Date:
Patient Address:
Date of Birth:
Detailed Description of Requested Amendment:
Reason for Requested Amendment:

NOTE: HENDRICKS REGIONAL HEALTH cannot delete or destroy any information already included in your medical record. HENDRICKS REGIONAL HEALTH can only add clarifying or correcting statements.

HENDRICKS REGIONAL HEALTH must tell you within sixty (60) days if HENDRICKS REGIONAL HEALTH will amend your protected health information as you requested or tell you that HENDRICKS REGIONAL HEALTH needs more time (up to thirty (30) extra days) to reach a decision regarding your request to amend.

If HENDRICKS REGIONAL HEALTH decides to amend the health information as you requested, HENRICKS REGIONAL HEALTH will send the amendment to any person who received the information before it was amended. Are there any such persons who need the amended information?

☐ **No** Initials: ____________________________ ☐ **Yes** Initials: ____________________

∗ΔΙΣΧΛΟΣΕ∗

If yes, I authorize Hendricks Regional Health to notify the following person/facility of the amendment.

Name______________________________ Name______________________________
Address____________________________ Address____________________________
City, State, Zip_______________________ City, State, Zip_______________________

HENDRICKS REGIONAL HEALTH will also send the amendment to other persons that HENDRICKS REGIONAL HEALTH knows received the information before it was amended if they relied, or might in the future rely, on the information to your detriment (harm). Do you agree to this?

☐ **No** Initials: ___________________ ☐ **Yes** Initials: ___________________

HENDRICKS REGIONAL HEALTH does not have to amend your information if:

1. HENDRICKS REGIONAL HEALTH did not create the information, unless the person who created the information is unavailable to act on our request to amend it (for example, the doctor who originally created the information has died). If this exception applies to you, please explain:

   ____

2. The information is accurate and complete.

3. You do not have the legal right to access the information you want amended.

4. The information you want amended is not part of your designated record set. This includes your medical records, billing records and records containing your protected health information that are used by us to make decisions about you.

Date:_______________________ Time:_______________________AM/PM

Signature:____
(legal representative)

If signed by someone other than patient, indicate relationship:_____________________________

Print name:____
(legal representative)

For more information about your privacy rights, see HENDRICKS REGIONAL HEALTH's "Notice of Privacy Practices" available on our website or at the Health Information Management Department at HENDRICKS REGIONAL HEALTH or by sending a written request to:

HENDRICKS REGIONAL HEALTH
Privacy Officer
317-718-7904
P.O. Box 409
Danville, IN 46122

ΔΙΣΧΛΟΣΕ

REQUEST FOR AMENDMENT OF PHI

If you believe your privacy rights have been violated, you may file a complaint with HENDRICKS REGIONAL HEALTH or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with HENDRICKS REGIONAL HEALTH, contact

HENDRICKS REGIONAL HEALTH
Privacy Officer
317-718-7904
P.O. Box 409
Danville, IN 46122

Office Use Only

Date Received: ____________________________ Date Approved: ___________________

Date Record Amended: _____________________ Not Approved: ____________________

Date Patient Notified of Decision: ____

Please mail completed form to: Director of Health Information Management
1000 E Main Street
P.O. Box 409
Danville, IN 46122

δισχλοσε