HEALTH RECORD CORRECTION AND AMENDMENT FORM

For Use with Policy ADM.0328 – Right to Amend Protected Health Information

Patient Name: ____________________________________ Patient Birthdate: ______________________

Patient Address:

____
____
____
____

Patient Account #: ____________________ Date of Entry to be amended: ________________________

Explain how the information entered on your health record is incorrect or incomplete. Include what the information should say to be more accurate or complete.

____
____

Do you need this amendment sent to anyone to whom we may have disclosed the information in the past? If so, please indicate the name and address of the individual or organization.

Name and Address:

____
____
____
____

____ ___________________

Signature of Patient or Legal Representative Date

FOR BAY AREA HOSPITAL USE ONLY:

Date Amendment Request received:_______________Amendment Status:_____Accepted______Denied

If Amendment Request is denied, check reason for denial:

______ The Protected Health Information was not created by this organization

______ The Protected Health Information is not available to the patient for inspection as required by law (e.g., psychotherapy notes)

______ The Protected Health Information is not part of the patient's health record

______ The Protected Health Information is accurate and complete.

Name of Staff Member:______________________________________ Title:_________________________

Comments of Healthcare Practitioner:

____
____

____ _________________________

Signature of Privacy Officer Date