



REQUEST FOR CORRECTION/AMENDMENT OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Type of Entry to be Amended: _____

- ? *Visit note*
- ? *Nurse note*
- ? *Hospital note*
- ? *Prescription information*
- ? *Patient history*

Please explain how the entry is inaccurate or incomplete.

Please specify what the entry should say to be more accurate or complete.

Signature of Patient or Legal Guardian

Date

Print Name of Patient or Legal Guardian

Amendment has been:

- ? Accepted
- ? Denied
- ? Denied in part, Accepted in part

If denied (in whole or in part)*, check reason for denial:

- ? PHI was not created by this organization.
- ? PHI is not available to the patient for inspection in accordance with the law.
- ? PHI is not a part of patient's designated record set.
- ? PHI is accurate and complete.

Comments from healthcare provider who provided service:

Name of Staff Member Completing Form: _____

Title: _____

Signature of Healthcare Provider Who Provided Service

Date

*If your request has been denied, in whole or in part, you have the right to submit a written statement disagreeing with the denial to the practice, **Amy Kaplan, M.D., Privacy Officer 9715 Medical Center Drive, Suite 436, Rockville, Maryland 20850 301.279.6750**. If you do not provide us with a statement of disagreement, you may request that we provide to you copies of your original request for amendment, our denial, and any disclosures of the protected health information that is the subject of the requested amendment. Additionally, you may file a complaint with our Privacy Officer **Amy Kaplan, M.D., Privacy Officer 9715 Medical Center Drive, Suite 436, Rockville, Maryland 20850 301.279.6750** or the Secretary of the U.S. Department of Health & Human Services.

***PRACTICE MUST INFORM PATIENT THAT A WRITTEN REQUEST IS REQUIRED, AND THAT THE PATIENT IS REQUIRED TO PROVIDE A REASON TO SUPPORT THE REQUESTED CHANGE.**