

REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION

Request Date: ____ / ____ / ____

Individual Name: _____

Date of Birth: ____ / ____ / ____ Social Security Number: _____

Patient Address: _____

Telephone Number: Home (_____) _____ Work (_____) _____

Medical Record No.: _____

After review of my medical record, I am requesting that information on the following service date(s) _____ be amended/supplemented with certain information and added in the form of an addendum to my medical record. I am requesting this amendment because: _____

I understand that Alton Memorial Hospital may or may not amend/supplement my medical record based on my request and under no circumstances, can Alton Memorial Hospital alter the original documentation of my medical record.

Amendment Request:

I request the following amendment/supplement be made to my medical record:

_____/_____/_____ ____:_____ _____ _____
DATE TIME SIGNATURE OF PATIENT OR PRINTED NAME
PERSON AUTHORIZED TO SIGN/RELATIONSHIP

Do you know of anyone who may have received or relied on the information in question (such as your doctor, pharmacist, health plan, or other health care provider)?

Yes No

If yes, please specify the name(s) and address(es) of the organization(s) or individual(s):

DO NOT WRITE BELOW THIS LINE

REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION

For Alton Memorial Hospital Use Only:

Amendment has been: Accepted Denied

In response to your request, an amendment/supplement will be made part of your medical record.

Your request has been denied for the following reasons:

The information is accurate and complete.

The information was not created by Alton Memorial Hospital.

The information is not part of the Designated Record Set.

Federal law prohibits making the Information available to the patient for inspection (e.g. psychotherapy notes).

Other: _____

Staff comments: _____

_____/_____/_____ ____:____ _____ _____
DATE TIME SIGNATURE OF STAFF PERSON/TITLE PRINTED NAME

Statement of Disagreement:

If you do not agree with the above, you may submit a Statement of Disagreement that will become part of your medical record and included in any future disclosure of the subject medical information. Please outline the reason for your disagreement in the space provided below: (may attach no more than 2 pages). Mail to the address listed below.

I do not wish to submit a Statement of Disagreement. However, I am requesting that Alton Memorial Hospital includes in any future disclosure my request for amendment form and Alton Memorial Hospital's denial.

_____/_____/_____ ____:____ _____ _____
DATE TIME SIGNATURE OF PATIENT OR PRINTED NAME
PERSON AUTHORIZED TO SIGN/RELATIONSHIP

Forward or mail, postage pre-paid, this form to:

**Health Information Management – Data Integrity
BJC Health Care
MailStop 90-59-341
One Barnes-Jewish Hospital Plaza
St. Louis, MO 63110**

DO NOT WRITE BELOW THIS LINE