Patient Amendment Request Form

Patient Name: ____

Patient Address: ____

Patient DOB: ____

Requestor Name: ____

Requestor Phone Number: ____

Requestor Relationship to Patient: ____

By signing below, I acknowledge that am requesting the amendment of my Protected Health Information ("PHI") and/or medical record on the basis that I have described below. I understand that under certain circumstances this request may be denied. Please note, information in your original medical record *will not be changed or deleted*. If the amendment request is granted, the amendment will be added to your permanent medical record.

If your request is denied, you have the right to submit a written statement disagreeing with the denial, detailing your reason for the disagreement.

Description of the information to be amended:

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Reason for the requested amendment (outdated, incomplete, incorrect, etc.):

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____

Correct information to be amended to:

____

____

____

Date(s) of information to be amended: ____

Signature of Patient or Legal Representative:

____ Date: ______________________

Printed Name of Legal Representative (if applicable):

____

Relationship of Legal Representative to Patient:

____

Please send all patient HIPAA Requests to: **HIPAA Privacy Office** Stormont Vail Health Integrity and Compliance 1500 S. W. 10th Ave. Topeka, KS. 66604 Office: 785-354-6343 Fax: 785-354-6398 E-mail: Privacy@stormontvail.org	Patient Name: ______________________ Date of Birth: ______________________ Date of Request: ______________________