REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION

Please complete the following information:

1. Today's Date: _____
2. Patient Full Legal Name : _____
3. Date of Birth: _____ 4. Patient Medical Record Number: _____
5. Patient Address: _____
   City _____ State _____ Zip _____
6. Date of entry to be amended (e.g., date of visit, test):_____
7. Describe the information you want amended (e.g., demographic information, physician notes, test results) _____
8. What is your reason for making this request? _____
9. Please explain how the entry is incorrect or incomplete. What should the entry say to be more accurate or complete? _____
10. Would you like this amendment sent to anyone to whom we may have disclosed the information in the past? If so, please specify the name and address of the organization or individual.

Please attach supporting documentation and/or additional statements pertinent to the amendment request as applicable.

Signature of Patient or Legal Representative

_____ Date _____

For National Jewish Use Only:

Amendment has been: □ Approved □ Denied Date Received: _____

Signature of Health Information Management Designee: _____ Date/Time: _____

Signature of Privacy Official: _____ Date/Time: _____

□ Patient has not filed a Statement of Disagreement, but requests that any future releases include the requested amendment and denial information.

□ Patient has filed a Statement of Disagreement that must be released along with other documentation with any future releases of information.

□ Facility/provider appended written response (rebuttal) and forwarded to patient.

□ Facility/provider did not provide a response/rebuttal.