



AMENDROI



AMENDMENT OF PATIENT PROTECTED HEALTH INFORMATION (PHI) REQUEST FORM

UCH-PHI-12, Rev. 1/18

LOCATION:

Daniel Drake Center University of Cincinnati Medical Center West Chester Hospital UC Physicians Company

You have the right to request _____ **(insert name of entity)** to make amendments to the protected health information (PHI) that the _____ (name of entity) retains on your behalf if you believe something in that information is in error or needs to be amended. We are not always required to make the amendments you request but each request will be carefully reviewed and amendments made if warranted. You will be notified when your request has been approved or denied.

Last Name: _____ First: _____ Middle: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Last 4 digits SS#: _____ DOB: _____

MRN _____ Encounter # _____

Please provide as much detail as possible regarding the amendment you seek in your medical record. Be as specific as possible regarding the record type, the location, the date and the problem. For instance, "my laboratory test results from April 15, 2003 show a blood test that was not performed."

Please state as precisely as possible the amendment you wish made to the record.

If you are aware of any other person(s)/entity (for example a physician(s) or another hospital) that may have a copy of the medical record you seek to have amended, please list the name(s) and addresses here.

I hereby authorize _____ **(name of entity)** to notify the persons/entities I have listed above that may have a copy of the record I seek to have amended and to provide them with the amended information.

Signature Patient/ Legal Representative*

Date/Time

*Describe scope of authority to act for patient: _____