Request for Amendment/Correction of Protected Health Information

Last Name	*First*	*Middle*	*Date of Birth*	*Request Date*

Street Address	*City*	*State*	*Zip*	*MR/Account #*

What Needs to be Amended/Corrected

Entry to be Amended:	
Date & Author of Entry:	

Please explain how the information is incorrect or incomplete. What should the information state to be more accurate or complete?

If this amendment is accepted, would you like this amendment sent to anyone to whom we may have disclosed this information in the past? If so, please specify the name and address of the organization or individual.
Name(s) & Address(es):

I understand that the provider may or may not amend the medical record based on my request, and under no circumstances is the provider permitted to alter the original medical record. In any event, this request for an amendment will be made part of my permanent medical record.

Signature of Patient/Representative	Print Name	Date *(mm/dd/yyyy)*

For Lamoille Health Partners Internal Use Only

Date received (mm/dd/yyyy)	☐ Amendment Accepted by Lamoille Health Partners ☐ Amendment Completed ☐ Amendment Sent to Patient/Representative requested entities	☐ Amendment Request Denied

If denied, check reason for denial:

☐ PHI was not created by this organization
☐ PHI is not available to the individual for inspection as permitted by federal law (e.g., psychotherapy notes)
☐ PHI is not part of designated record set
☐ PHI is accurate and complete

Notice of Decision Letter for Request to Amend PHI Letter was sent within 60 days (attach letter) Date Sent: ____/_____/______

Individual’s Statement of Disagreement received (attach) ☐ Yes ☐ No

Lamoille Health Partners Rebuttal Statement Letter Sent (attach) ☐ Yes ☐ No Date Sent: ____/_____/______

Signature of Primary Care Practitioner	*Date*
Signature of Privacy & Security Officer	*Date*

Origin 07/16/2016
Form #500.332E