Request for Amendment of Protected Health Information Form

Instructions

You have the right to request that Baptist correct or amend personal health information that it maintains about you if you believe the information is inaccurate or incomplete. Please complete this entire form to request that Baptist correct or amend your personal health information. There are certain circumstances in which your request may be denied. We will notify you of our decision to either accept or deny your request within 60 days, or notify you that an extension is necessary.

Patient Name: _____ D.O.B. _____

Current Address: _____

Phone No. _____ SSN _____

1. Please describe in detail the information that you believe is inaccurate or incomplete. To help us identify the information, please provide as much information as possible about the date, location, and author of the information. If you have a copy of the record containing the information, please attach the copy to assist us in reviewing your request. Please be as specific as possible.

   _____

   _____

   _____

2. Describe the changes or additions that you believe need to be made to the record to make it accurate and complete. Please be specific. _____

   _____

   _____

3. If we agree to your request for amendment, we will make reasonable efforts to notify any other person or entity that you list below that may have received a copy of the information and needs the amendment (for example, your family physician or pharmacist). We will also notify other persons or entities that we know we have the information and may have relied on it, or may in the future rely on the inaccurate information.

   Name: _____ Address: _____

   Name: _____ Address: _____

   Name: _____ Address: _____

_____ _____

Signature of patient or patient's personal representative Date

_____

Authority of personal representative

WE WILL NOT PROCESS THIS REQUEST UNLESS IT IS SIGNED BY YOU OR YOUR REPRESENTATIVE

A COPY OF YOUR PHOTO ID MUST ACCOMPANY THIS REQUEST