Compass Health Network

Request for Amendment of Protected Health Information

Patient Name: _____ DOB: _____

Medical Record #: _____ Phone Number: _____

Patient Address: _____

Date(s) of entry to be amended: _____

Type of entry(s) to be amended: _____

Please explain how the entry is incorrect or incomplete. What should the entry say to be more accurate or complete? _____

_____

_____

Would you like the amendment sent to anyone whom we may have disclosed information prior to your amendment request? If so, please provide the name and address of the organization or individual.

_____ _____

Name Address

_____ _____

Signature of Patient or Personal Representative Date

_____

Authority to sign if not the Patient

For Compass Health Network Use Only:

Date Received: _____ Received by: _____ Amendment: ☐ Accepted ☐ Denied

If denied, check reason for denial:

☐ PHI was not created by Compass Health Network

☐ PHI is not a part of patient's Designated Record Set

☐ PHI is not available to the patient for inspection as required by Federal Law (e.g. Psychotherapy Notes)

☐ PHI is accurate and complete

Comments of Health Care Practitioner (Clinician-author): _____

_____

_____

_____ _____

Name of Health Care Practitioner Title

_____ _____

Signature of Health Care Practitioner Date/Time

_____ _____

Signature of HIM Director/Privacy Officer Date/Time