REQUEST TO AMEND MY PROTECTED HEALTH INFORMATION

I, _____, request a change to my record(s) for my visit to

_____

(INSERT PHYSICIAN, DEPARTMENT AND/OR CLINIC NAME)

On the following date(s) of service: _____.

I request the following change(s) to be made: _____

_____

_____

_____

_____

I request the change(s) because: _____

_____

_____

_____

_____

Patient Name: _____
(first) (middle initial) (last)

Signature: _____ Date: _____

Address: _____
(street address)

_____
(city) (state) (zip code)

Phone: _____
(home phone with area code) (cell phone with area code)

Medical Record Number: _____ Birth Date: _____

South Peninsula Hospital

Health Information Management Department
South Peninsula Hospital
4300 Bartlett St.
Homer, AK. 99603
Phone: 907-235-0232 Fax: 907-235-0252

If you would like the response to be sent to a different address than what you have provided above, please fill in the following:

Patient/Representative Name: _____
(first) (middle initial) (last name)

Mailing Address: _____
(street address)

_____
(city) (state) (zip code)

1. I understand that my request will be considered, but may not be granted if South Peninsula Hospital determines that my protected health information or record that is subject to this request:
    a. Was not created by South Peninsula Hospital, unless I provide a reasonable basis to believe that the originator of protected health information is no longer available to act on the requested amendment:
    b. Is not part of my medical or billing record;
    c. Would not be available to me for inspection under applicable law dealing with access to protected health information, or;
    d. Is accurate and complete.
2. I understand that I will receive a response within 60 days to amend or reject my request.
3. If South Peninsula Hospital is unable to act on the amendment within 60 days, South Peninsula Hospital may extend the time to act by no more than 30 days, provided that:
    a. South Peninsula Hospital sends me a written reason for the delay and the date by which they will complete its action on my request; and
    b. South Peninsula Hospital may have only one extension of 30 days to act on my request.

Patient Signature: _____ Date: _____

Patient Printed Name: _____

Physician Name: _____ Date: _____

Physician Signature: _____

☐ Approved or ☐ Denied

Reason if Denied: _____

_____

_____

_____

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If you are NOT the patient, but are signing on behalf of the patient, please complete the following:

I, _____, confirm that I am the legally appointed representative for the above mentioned patient and that I have one of the following relationships with the patient or one of the following documents:

Please CIRCLE one of the following:

- Parent with parental rights
- Medical Power of Attorney
- Registered Kinship Care Representative
- Surrogate Decision Maker
- Court Appointed Guardian
- Legally Appointed Healthcare Agent
- Court Appointed Personal Representative of Deceased

Representative Signature: _____ Date: _____

Address: _____ Phone: _____

****YOU MUST ATTACH PROOF OF YOUR AUTHORITY TO ACT ON BEHALF OF THE PATIENT AS CIRCLED ABOVE (OTHER THAN PARENT)****

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