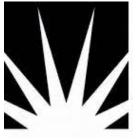

REQUEST TO AMEND PROTECTED HEALTH INFORMATION

PATIENT IDENTIFICATION:

Name: ____
(First) (Middle Initial) (Last)

Date of Birth: ____________________ Medical Record Number: ____________________________

Street Address: ____

City: ______________________ State: ________________ Zip Code: ______________

Home Phone: ______________________ Cell Phone: ______________________

CHANGE REQUEST:

Date(s) of Service: ____

Physician/Advanced Practice Provider (APP), Department, and/or Clinic Name:

____

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

____

____

____

____

REASON FOR CHANGE:

I request the change(s) because:

____

____

____

MAILING ADDRESS: ☐ Same as above

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

Patient/Representative Name: ____

Street Address: ____

City: ______________________ State: ________________ Zip Code: ______________

Initials of Authorized Requesting Party: ____________

Health Information Department - South Peninsula Hospital
4300 Bartlett St., Homer, AK 99603, 907-235-0232, fax 907-235-0252

South Peninsula Hospital

PATIENT CONFIRMATION:

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 Name (Printed)	Patient Signature	Date	Time

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:

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

Representative Name (Printed)	Representative Signature	Date	Time

Address: ______________________________ Phone: ______________________

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

STATUS OF REQUEST: ☐ Approved ☐ Denied

Reason if Denied:

____

____

____

Physician/APP Name (printed)	Physician/APP Signature	Date	Time