



PATIENT REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION

NOTICE: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) allows you to request an amendment to our records containing your Protected Health Information (PHI) defined by HIPAA as Individually Identifiable Health Information. Please use this form to describe the records and the amendment to those records that you are requesting.

Patient Name: _____ Birth Date: _____

Phone number: _____

Patient Address: _____

Date of entry to be amended: _____

Type of entry to be amended: _____

I do hereby request _____ (Name of Facility) to amend my PHI as set forth below.

Please explain how the entry is incorrect or incomplete. In your opinion, what should the entry say to be more accurate or complete? (Please attach separate pages as necessary.)

If the healthcare practitioner agrees with your request and completes an amendment to the medical record, would you like this amendment sent to anyone to whom we may have disclosed the information in the past? If so, please specify the name and address of the person or entity.

Understanding and Acknowledgement

I acknowledge that the amendment I am requesting may be refused for reasons permitted under HIPAA. I understand that if my request is denied I am entitled to a written explanation, and I may submit a written statement disagreeing with the denial. The written statement will be maintained in the medical record and included in future disclosures of the protected health information that is the subject of the amendment request

If making this request for a patient other than myself, I certify I am the patient's legally authorized personal representative and am requesting this amendment in good faith and in the best interest of the above named patient. I understand INTEGRIS may require documentation establishing legal authority of personal representative for the above named patient, including but not limited to, valid durable power of attorney for health care.

Signature of Person Submitting Request

Date

Print Name of Person Submitting Request

Relationship to Patient

For Facility Use Only:

Date Received: _____ Amendment has been: _____ Accepted _____ Denied

If denied, check reason for denial:

- _____ Amendment request is not in writing or incomplete
- _____ Invalid reason to support the request
- _____ PHI was not created by this organization
- _____ Individual or entity that created the PHI is not available to make the amendment
- _____ PHI was not part of the patient's medical record maintained by INTEGRIS
- _____ 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 Healthcare Practitioner or HIM representative _____

Signature of Healthcare Practitioner
or HIM Representative

Date

Print Name of Healthcare Practitioner
or HIM Representative

Please return completed form to:

**INTEGRIS HIM Department
3366 NW Expressway, Bld D Ste.
C20 Oklahoma City, OK 73112**

Fax: (405) 552-8773

Email: HealthInfoManagement@integrisok.com

Questions? (877) 778-7211

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