INTEGRIS HEALTH

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

INT-1677 Release of Information Forms
Rev 10/20, 04/22

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 **3433 NW 56th Street, Bld. B Ste. C50** **Oklahoma City, OK 73112**	**Fax: (405) 552-8773**
	Email: HealthInfoManagement@integishealth.org
	Questions? (877) 778-7211