Marshall
Medical Centers
Many Reasons. One Choice.

REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION

PATIENT NAME: ________________________________ **BIRTH DATE:** ____________________

MEDICAL RECORD NUMBER: _______________ **ACCOUNT NUMBER:** ____________________

PATIENT ADDRESS: ____

I hereby request that the hospital amend (*Check all that apply)*:

_____ My medical records
_____ My billing records
_____ Other (*Please describe*) ____

Date(s) of information to be amended (e.g., date of office visit, treatment, or other health care services):
FROM (date) ______________________________ TO: (date) ______________________________
FROM (date) ______________________________ TO: (date) ______________________________

What is your reason for making the request?

____

____

How is the entry incorrect, incomplete, or outdated?

____

____

What should the entry say to be more accurate or complete?

____

____

Do you know of anyone who may have received or relied on the information in question (such as your doctor, pharmacist, health plan, or other health care provider)? _____ Yes _____ No

If yes, please specify the name(s) and address(es) of the organization(s) or individual(s).

____

____

I understand that the hospital may deny this request as permitted under federal law, and that I will be informed by the hospital concerning the basis for the denial along with instructions concerning my right to submit a statement disagreeing with decision to accept or deny my request within sixty (60) days of receiving this request.

Signed: ____
(Patient) (Date)

____
or (Patient Representative) (Relationship to Patient) (Date)

Printed: ____
(Patient Representative) (Relationship to Patient) (Date)

Return to: Health Information Management, Marshall Medical Centers,
227 Brittany Road, Guntersville, AL 35976 or fax to 256-894-6636

Effective 5/2014