DERMATOLOGY
Healthcare Excellence

REQUEST TO AMEND PROTECTED HEALTH INFORMATION FORM

Date: _____

Patient Information:

First Name: Last Name:

Address: City: LAkewood]\

State: CO Zip: 80210 Date of Birth: Phone Number:

Please describe the information you are requesting to be amended and the reason for your request:

If your record is amended, identify all persons or organizations that should receive a copy of the amendment record or information:

Name:	**Address:**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I request and authorize that the amended record be sent to the individuals and organizations described above. If my protected health information health record is not amended, I request and authorize that this request and any denial correspondence be sent to the individuals and organizations described above.

I understand that my request may be denied if:

1. The protected health information was not created by Dermatology Healthcare Excellence or if the individual/ entity who kept or created the protected health information is no longer available to act upon my request;
2. The protected health information is not part of a designated record set;
3. I do not have a right to access the protected health information under 45 C.F.R. 164.524; or
4. The protected health information is accurate and complete without amendment.

_____

Patient or Personal Representative Signature

_____

Print Name

_____

Relationship of Personal Representative

For Office Use Only

Date Request for Amendment Received: _____

Deadline to Respond: _____ (60 days after request received)

Date Patient Notified of Response: _____

Response to Request:

☐ **Accepted**

☑ **Denied**
If denied, check reason for denial:
◯ **PHI not created by our office.**
◯ **PHI is accurate and complete without amendment.**
◉ **Other reason (describe) _____**

Additional comments: _____

_____ _____
Privacy Officer/Designee Signature **Date**

_____
Privacy Officer/Designee Printed Name