



Request for Amendment of Protected Health Information Form

<i>Patient's Name</i>			
<i>Patient's Address</i>			<i>Date of Birth</i>
<i>Phone #</i>	<i>Last 4 of SSN (Voluntary)</i>		<i>Medical Record #</i>
**Complete the following only if the person authorizing the use or disclosure is not the patient:	<i>Representative Name</i>	<i>Relationship to Patient</i>	<i>Verification of Identity and Authority</i>
	<i>Representative's Address</i>		<i>Phone #</i>
Complete all areas below with as much detail as possible:			
Type of Entry(ies) or Report(s) to be Amended:		Date(s) of Entry(ies) to be Amended:	
Please explain the information that is incorrect or incomplete. Include the information that you feel should be included in order to make the record more accurate or complete.			
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 organization or individual.			
<i>**I understand that this amendment request will become a part of my designated record set. I also understand that this request is subject to the review of a medical provider who will use his/her professional judgment as to whether or not my record should be amended.</i>			
Signature of Patient or Legal Representative:			Date:

Complete all parts of the form, print out and sign and date. Mail form to HIM at Nash UNC Health Care, 2460 Curtis Ellis Drive, Rocky Mount, NC 27804.



UNC HEALTH CARE SYSTEM INTERNAL USE ONLY	
<i>Date Received:</i>	<i>Determination:</i> <input type="checkbox"/> Accepted <input type="checkbox"/> Denied
<i>If denied, check reason for denial:</i>	
<input type="checkbox"/> PHI was not created by UNC HCS	<input type="checkbox"/> PHI is not part of the patient's designated record set
<input type="checkbox"/> PHI is not available for inspection as permitted by Fed. Law	<input type="checkbox"/> PHI is accurate and complete
Comments:	
Date patient was informed of amendment or denial: (list date) _____	
Signature/Title of Staff Member	Date:

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