| Dartmouth-Hitchcock<br>**Request for Amendment of Protected Health Information (PHI)** | MRN:<br>Name:<br>Date of birth: |
|---|---|

Address: _____

Phone: _____

What is your reason for making this request: _____

_____

_____

Describe the document(s) you want amended. Please include all relevant dates. _____

_____

_____

_____

How do you believe the document should read? _____

_____

_____

_____

Do you know of anyone who may have received or relied upon the information in question, such as your doctor, pharmacist or insurance company)? ☐ Yes ☐ No

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

_____

_____

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Printed name of Personal Representative Legal Authority of Personal Representative

| Dartmouth-Hitchcock<br><br>**Request for Amendment of Protected Health Information (PHI)** | MRN:<br><br>Name:<br><br>Date of birth: |
|---|---|

FOR DEPARTMENT USE ONLY

**For Privacy Office**

☐ Request for Amendment is accepted.

☐ Request for Amendment is denied.

Check the reason for denial:

☐ Health Information was not created by this organization.

☐ Federal Law prohibits making the health information in question available to the patient for inspection.

☐ Information is not part of the designated record set.

☐ Originator of the record is not available because _____

☐ Information is accurate and complete.

_____ _____

Signature of Privacy Office Personnel Date

**For Originator of Document:**

☐ Request for Amendment is accepted. I have amended the documentation in the medical record, electronic and/or paper.

☐ Request for Amendment is denied.

Check the reason for denial:

☐ Health information is accurate and complete as currently documented.

☐ Other: _____

_____ _____

Signature of Originator of Document Date

Original to Medical Record
At your request we will provide you a copy of this form.

Health Information Services Approval: 2/10/2011