

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How is the entry incorrect, incomplete, or outdated?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**