PROMEDICA AMENDMENT REQUEST FORM

ProMedica allows you the right to request an amendment to the medical and health information we retain on your behalf, if you believe something in that information is in error or needs to be amended. We are not always required to make the amendment you request, but each request will be carefully reviewed. You will be notified in writing within 60 days if your request has been approved or denied.

Patient Name: _____ Birthdate _____

Patient Address: _____

Daytime Phone Number: _____

Name of Facility Treatment Occurred: _____

Date(s) of Entry: _____

Title of Document where error occurred: _____

Please explain specifically how the documentation is incorrect or incomplete.

_____

_____

_____

Please explain specifically what the documentation should say to be more accurate or complete? **Please attach additional sheets or attach copies of the incorrect documentation, when possible**. _____

_____

_____

_____

_____

I hereby authorize ProMedica to notify the persons/entities I have listed below that may have a copy of the record I seek to have corrected and to provide them with the amended information. You must include specific names and addresses.

Names	Addresses
_____	_____
_____	_____
_____	_____

_____ _____

Signature of Patient or Legally Authorized Representative Date

You MUST attach proof of your authority to act on behalf of the patient if signed by the patient's legal representative

I understand that my request will be considered, but may not be granted if ProMedica determines that my protected health information or record that is subject to this request:

- Was not created by ProMedica, unless I provide a reasonable basis to believe that the originator of protected health information is no longer available to act on the requested amendment;
- Is not part of my medical or billing record;
- Would not be available for me for inspection under applicable law dealing with access to protected health information; or
- Is accurate and complete.

RETURN COMPLETED FORM TO:

ProMedica Health Information Management
ATTN: Amendment Request
MSC-J28105
300 N. Summit Street
Toledo, Ohio 43604
Phone: (419) 291-4172
Fax: (419) 480-1226

FOR OFFICE USE ONLY

Medical Record Number:

Account Number:

Date Received:

Amendment has been:

☐ Accepted

☐ Denied

If denied, check reason for denial:

☐ Protected Health Information (PHI) was not created by this organization

☐ PHI is not part of patient's designated record set

☐ PHI is not available to the patient for inspection as required by federal law (e.g., psychotherapy notes)

☐ PHI is accurate and complete

Comments of Reviewer:

_____

Name of Staff Member Title

_____ _____

Signature of Healthcare Practitioner Date