[Insert Facility Name]

REQUEST FOR CORRECTION/AMENDMENT OF PROTECTED HEALTH INFORMATION FORM

RESIDENT NAME	DATE OF BIRTH	RESIDENT RECORD NUMBER
RESIDENT ADDRESS	DATE OF ENTRY TO BE CORRECTED/AMENDED	

1. Information to be corrected/amended

_____

_____

_____

2. Please explain how the entry is incorrect or incomplete. What should the entry say to be more accurate or complete? Use additional sheets if needed and attach to this form.

_____

_____

_____

3. If you agree, the Facility will make a reasonable effort to provide the amendment to other persons who the Facility knows received the information in the past and who may have relied, or are likely to rely, on such information in a manner that may be detrimental to your health care.
   - ☐ I agree to allow the Facility to release any amended information to individuals or entities as described above.

4. Would you like this amendment sent to anyone else who received the information in the past?
   - ☐ Yes
   - ☐ No

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

_____ _____

Signature of resident or personal representative
(If Personal Representative, state relationship to resident)

Date