Hackensack Meridian *Health*

REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION

INTERNAL USE ONLY
Date Received:
_____ / _____ / _____

As a patient, you have the right to request that protected health information about you that is maintained by Hackensack Meridian Health be amended if you believe it is incorrect or incomplete. HMH will review the request with the provider and will either grant the request or will provide an explanation why the request cannot be granted. Upon receipt of the patient's written request, the provider has 60 days to respond with the written notification. Hackensack Meridian Health will notify you if additional time is required.

If the provider accepts the patient's request to amend the record, the provider must make the change in the medical record, and then inform the patient that the change has been made.

If the request is not granted, you will have the right to submit a statement of disagreement that will accompany future disclosures of the information by HMH.

You will need to submit a completed Request for Amendment form. The form must be signed, and verification of identity is required.

Please complete the form below and return to PatientAmendment@hmhn.org

You can also mail, fax the completed form to 732-951-7947.

REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION FORM

Patient Name: _____

Address: _____
Street City State Zip Code

Contact Number: _____ Date of Birth: _____

I hereby request that Hackensack Meridian Health and/or one of its affiliates amend [please check all boxes that apply]:

Location of Services:

☐ Bayshore Medical Center	☐ Ocean University Medical Center	☐ Carrier Clinic	☐ Palisades Medical Center
☐ Hackensack University Medical Center	☐ Raritan Bay Medical Center	☐ Old Bridge Medical Center	☐ Southern Ocean Medical Center
☐ JFK University Medical Center	☐ Riverview Medical Center	☐ Jersey Shore University Medical Center	
☐ Other: (specify)			

My medical records from_____ (date) to_____ (date).

Please explain how the information is incorrect or incomplete.

_____

_____

_____

_____

What should the information state to be more accurate or complete?

_____

_____

_____

_____

Note: any requested changes regarding Date of Birth or Address, will require appropriate documentation to support.

Hackensack Meridian *Health*

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I understand that Hackensack Meridian *Health* may or may not approve this request. I also understand that Hackensack Meridian *Health* is not able to alter the original documentation in a record under any circumstances.

I further understand Hackensack Meridian *Health* will notify me whether my requested is granted or denied, within sixty (60) days of receiving this request. If Hackensack Meridian *Health* is unable to comply with my request within this timeframe, I understand that it may extend the applicable deadline for up to an additional thirty (30) days by notifying me in writing.

_____

Signature of patient or Patient's Personal Representative Date

_____

Printed name of the person signing and relationship to the patient

If you are NOT the patient but are signing on behalf of the patient, please comment below:

I, _____ , am the (check which applies)
(print name)

- ☐ Parent with Parental rights *(not sufficient for substance abuse records)*
- ☐ Registered Kinship Care Relative *(not sufficient for substance abuse records)*
- ☐ Court Appointed Guardian
- ☐ Legally appointed Healthcare Agent *(not sufficient for substance abuse records)*
- ☐ Medical Power of Attorney *(not sufficient for substance abuse records)*
- ☐ Power of Attorney *(not sufficient for substance abuse records)*
- ☐ Surrogate Decision Maker *(not sufficient for substance abuse records or mental health records)*
- ☐ Court Appointed Personal Representative of Deceased

Representative's Signature: _____ Date:_____
(Required)

Address:_____
Street City State Zip Code Phone

You MUST attach proof of your authority to act on behalf of the patient as checked above (other than parent).

Submit completed form via email: PatientAmendment@hmhn.org

You can also mail, fax the completed form to 732-951-7947.

Director of Health Information
100 Tormee Drive
Second Floor, Office # 838
Health Information Dept.
Tinton Falls, NJ 07712