NEMOURS CHILDREN'S HEALTH

100119

Patient Name:
MRN:
DOB:

Request for Amendment of Health Information

Please complete the following information: **Date: _____**

Patient's Address: _____

1. Date(s) of Entry to be amended/corrected: _____

2. Type(s) of Entry to be amended/corrected: _____

3. Please explain how the entry(s) is incorrect or incomplete:

_____
_____
_____
_____
_____

4. What should the entry(s) say in order to be more accurate or complete?

_____
_____
_____
_____
_____

5. Would you like this amendment sent to anyone to whom we may have disclosed information to in the past? ☐ **NO** ☐ **YES**

If so, please specify the name and address of the organization or individual:
Name: _____
Address: _____

Name: _____
Address: _____

Name: _____
Address: _____

_____ _____
Date **Patient/Legal Representative's Signature**

_____
Relationship to Patient

NEMOURS CHILDREN'S HEALTH

Patient Name:
MRN:
DOB:

Request for Amendment of Health Information

Nemours will act on this completed request for amendment no later than 60 days after receipt of your request, unless one 30-day extension has been requested. If an extension is requested, Nemours will notify you of this extension and provide you with the date by which we will complete your request.

Your request for Amendment may be denied. If so, you will receive a statement explaining the denial and the process on how to submit a written statement of disagreement and the basis of the disagreement. You will also receive information on how you may lodge a complaint to Nemours Privacy Officer or the Secretary of Health and Human Services.

INTERPRETER'S SIGNATURE: (To be completed only when appropriate)

I certify that I am fluent in English and the native language of the person indicating consent on the above form. I certify that I have accurately and completely interpreted the contents of this form, and that the patient and/or adult legally responsible for the minor child has indicated their understanding of the contents of this form.

_____	_____	_____	_____AM
Interpreter's Signature &/or Telephone Identification Number	Print Name	Date	Time PM

To be completed by Nemours:

Identification Number Amendment has been: ☐ **Accepted** ☐ **Denied (If denied, check the reason for denial):**

- ☐ **PHI (Protected Health Information) was not created by this organization**
- ☐ **PHI is not part of the patient's designed record set**
- ☐ **Federal law forbids making the PHI in question available to the patient for inspection (e.g., Psychotherapy notes)**
- ☐ **PHI is accurate and complete**

Comments of Health Care Provider:

_____

_____

_____

_____

Amendment has been reviewed by the following Healthcare Providers:

_____	_____	_____	_____AM
Provider's Signature	**Please Print Name**	**Date**	**Time PM**
_____	_____	_____	_____AM
Provider's Signature	**Please Print Name**	**Date**	**Time PM**

Notification was sent to the Patient/Legal Representative on: _____
Date

_____	_____	_____	_____AM
Staff Member's Signature / Title	**Please Print Name**	**Date**	**Time PM**

*Nemours includes: The Nemours Foundation, a Florida not-for-profit corporation, its operating divisions and sites, and its affiliates and subsidiaries, including Nemours Children's Hospital, Delaware; Nemours Children's Hospital, Florida; Nemours Children's Hospital, Surgery Center, Bryn Mawr; and Nemours Children's Hospital, Surgery Center, Deptford; and all entities operating under the name Nemours Children's Health.