

Request for Amendment of Health Information



Please complete the following information: Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Patient's Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Patient MR#: \_\_\_\_\_

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

\_\_\_\_\_
Relationship to Patient



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 you may use 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.

(To Be Completed Only When Appropriate)

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Translator

To be completed by Alfred I. duPont Hospital for Children/Nemours Children's Clinic

**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 designated 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:**

_____ Date	_____ Please Print Name	_____ Signature of Provider
_____ Date	_____ Please Print Name	_____ Signature of Provider

**Notification was sent to the Patient/Legal Representative on:** \_\_\_\_\_  
Date

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Staff Member

\_\_\_\_\_  
Title

\_\_\_\_\_  
Please Print Name