

Health Information Management
Medical Center Blvd., Winston-Salem, NC 27157
336-716-6819

Request for Amendment of or Addition to Protected Health Information

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have a right to request that health information that pertains to you be amended if you believe that it is incorrect or incomplete (see page 10 of the enclosed Notice of Privacy Practices). We will review your request and either grant your request or explain the reason why it will not be granted.

In the event that your request is not granted, you have the right to submit a statement of disagreement that will accompany the information in question for all future disclosures. We will not make the requested changes if:

- 1) They do not involve your medical records, billing records, or other records that we use to make decisions about you;
- 2) They involve records that you do not have the right to access;
- 3) We did not create the information (unless the person or entity that created the information is unable to act on your request); or
- 4) The information is accurate and complete.

If we agree to amend your information, we will communicate the changed information to the person(s) or entity(s) that you have designated. We will also communicate the changed information to any other person(s) or entity(s) that we know have received the information before it was amended. If we are not able to act on this request in 60 days, we will notify you of the reason(s) for the delay.

If you request information to be sent to anyone other than yourself, and we do not have a valid current authorization on file with Medical Records, please complete the enclosed "Authorization for Use or Disclosure of Protected Health Information" form to enable us to release your information to the party requested.

NOTICE: Patients may seek to change information in their medical records in order to improve the accuracy or completeness of the information. The original information contained in the record will not be erased or obliterated as a result of this amendment.

Instructions:

- 1) Complete the information on the following page, and attach a copy of the medical record with changes clearly noted and the authorization form, if necessary.
- 2) Return form and documents to the attention of the HIM Data Integrity Coordinator at:
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I, _____ (*Print Name*) believe that the following health information pertaining to me is incorrect or incomplete (please also attach the information and identify its date and location in the medical record): _____

I believe that the information described above is incomplete or incorrect for the following reasons: _____

I hereby request that you amend the health information identified above as follows (*attach additional page(s) if necessary*): _____

Additionally, I request that the following people will be notified of the correction (see attached authorization form):

Name	Address
_____	_____
_____	_____
_____	_____

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

- Parent or guardian of minor patient;
- Guardian or conservator of an incompetent patient;
- Beneficiary or personal representative of deceased patient;
- Other (specify) _____

Patient's Name: _____ Date of Birth: _____
(First, Middle, Maiden, Last) *(Month/Day/Year)*

Copy of any medical record needing the amendment must accompany form.