HEALTH INFORMATION AMENDMENT REQUEST FORM

To request a correction or change (amendment) to your health information, please complete the information below and submit this form to: Atrium Health Corporate Health Information Management, P.O. Box 32861, Charlotte, NC 28232-2861. You will receive a response to your request within 60 days of the day we receive your written request.

Patient Name: ____ Date of Birth: ____

Address: ____ City: ________________________ State: _____ Zip Code: ________

Phone: (____) _______________________________________ Email Address: ____

Please name the Atrium Health Facility/Practice and location you want to change your record:

____

Include the name(s) of the Person/Caregiver/Provider who wrote the information you are asking us to change:

____

Include the treatment dates of the information and documents you want changed: ____

Describe the information you want changed:

____

____

What should the record say to be more accurate or complete?

____

____

____

List the name(s) of the people/organizations you would like us to notify of any changes made to your medical record:

Name	Address
____	____
____	____

Signature of Patient or Representative: ____ Date: _______________________

If signing as authorized representative, describe your authority to act for the patient, for example, parent, Healthcare Power of Attorney and submit documentation showing such authority, as appropriate: ____

For Atrium Health Use Only

Amendment has been: ____Accepted ____Denied ____Partially Accepted/Denied

If denied (fully or partially), check reason:

___ PHI was not created by Atrium Health

___PHI is accurate and complete

___ PHI is not part of the patient's designated record set

___ PHI is not available for amendment as permitted by federal law

Signature: ____________________________________ Print Name: ____ Date:___________________

Comments: ____

Atrium Health

Rev. July 2023

Place Patient Label Here