REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION

Patient Name: ___________________

MRN: ______________ DOB: ________

Treatment Location: _______________

To be completed by patient/authorized representative

Patient Name: ____ Date of Birth: _________________________________

Address: ____

City: ____ State: ______________________ Zip Code: _________________

Home Phone: (_____) ___________________________ Work Phone: (_____) ______________________________________

I have reviewed my health record; I do not feel the information in the record made by (name of provider): _______________________________________ ____ is correct for the following reason:

____.

The date(s) of service ____ should be updated with the following information:

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I understand I have the right to request an amendment to my Protected Health Information maintained in a designated record set at the Hospital. I understand the Hospital is not always required to make the amendments I have requested; however, my request for amendment will be carefully reviewed and amendments will be made when warranted. I understand that I will receive a written response regarding my request within sixty (60) days. If the Hospital denies my request (in whole or in part), I will receive an explanation of why it was denied and further options.

If other than patient's signature, a copy of legal paperwork verifying the patient's personal representative MUST accompany the request (e.g. court appointed guardian, durable power of attorney for health care). Exception: Parent signing for a patient under the age of eighteen. For a deceased patient, a court entry or order appointing a fiduciary, executor, or administrator, or letters of appointment received from Probate Court must accompany an amendment request signed by the named individual. IF the estate has not been probated, a completed amendment request, death certificate and personal representative form all MUST be submitted.

If your request is accepted and the appropriate amendment is made, a copy of the amended information may be sent to anyone who has previously received this information. If there is anyone you would like to receive this amendment, please specify the names and address of the organization(s) or individual(s):

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REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION

Patient Name: ____________________

MRN: ______________ DOB: ________

Treatment Location: _______________

Please return this form to Health Information Management:

- ❑ 301 U.S. Route One, Suite C, Scarborough, ME 04074
- ❑ LincolnHealth Miles, 35 Miles Street, Damariscotta, ME 04543
- ❑ Franklin Memorial Hospital, 111 Franklin Health Commons, Farmington, ME 04938
- ❑ Memorial Hospital, 3073 White Mountain Highway, North Conway, NH 03860
- ❑ Pen Bay Medical Center, 6 Glen Cove Drive, Rockport, ME 04856
- ❑ Southern Maine Health Care, 1 Medical Center Drive, Biddeford, ME
- ❑ Stephens Memorial Hospital, 181 Main Street, Norway, ME 04268
- ❑ Waldo County General Hospital, 118 Northport Avenue, Belfast, ME 04915-6009

Physician/Author/Designee's Response

- ❑ In response to your request for amendment, an addendum will be made to your permanent health record.
- ❑ Your request for amendment has been made a part of your permanent health record; however, your request has been denied for the following reason(s): The Protected Health Information
  - ❑ was not created by the organization, or the person or entity that created the information is no longer available to make the amendment.
  - ❑ is not part of the health information kept by or for the treating organization or provider.
  - ❑ is not available for inspection under the HIPAA privacy rule.
  - ❑ is accurate and complete.

Physician/Author/Designee's Comments:

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Date	Time AM|PM	X Signature ❑ Patient ❑ Parent ❑ Guardian ❑ Authorized Representative	Printed Name

If by telephone consent given by: ❑ Patient ❑ Other ____________________ Phone number ____________

Date	Time AM|PM	X Witness Signature (For phone consent or when patient is physically unable to sign)	Printed Name

Interpreter for: ❑ Sign Language ❑ Foreign Language ❑ Other ____________ Print Name or identifying information ____________

Date	Time 24 Hour	X Signature of Physician or Designee	Printed Name