PATIENT REQUESTS TO AMEND PROTECTED HEALTH INFORMATION

PATIENT REQUEST FOR AMENDMENT OF RECORDS

You have the right to request that we amend most information in our records that may be used to make decisions about you and your treatment for as long as we maintain the information in our records. Please see our Notice of Privacy Practices for a more detailed description of your rights to request amendment of this information and the process we follow once we have received your request. To request an amendment of records, complete and return the following request form.

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Address:

_____

_____

_____

Telephone:

_____

Email address:

_____

AMENDMENT REQUEST

Please answer the following questions. You may attach a separate page if more space is needed.

What type of medical record would you like amended?

Office Note _____ Medication ____ Medical History ____ Social History ____

Inpatient Records ____ Other _____

Date(s) of Service _____

What information would you like to amend?

_____
_____
_____
_____
_____
_____
_____

PATIENT REQUESTS TO AMEND PROTECTED HEALTH INFORMATION

Why do you believe the information should be amended?

_____
_____
_____
_____
_____

PATIENT UNDERSTANDING AND SIGNATURE

By signing below, I am requesting that LRGHealthcare amend my health information as I have explained above.

_____
Signature of Patient or Personal Representative

_____
Print Name of Patient or Personal Representative

_____
Date

SEND COMPLETED FORM TO:

LRGHealthcare
Attn: HIM
80 Highland Street
Laconia, NH 03246

For LRGHealthcare Use Only:

Date Received: ___/___/_____

Disposition of Request: ___ Granted ___Denied ____ Partially Denied

Patient Notified in Writing on This Date: ___/___/_____

Name of Medical Records Department Staff Member Processing This Request: _____

DATES REVIEWED:

DATE REVISED: 1/2020

(Reviewed by ETC)

Policy Reference Number:

1420158