The Reading Hospital and Medical Center

REQUEST TO AMEND PROTECTED HEALTH INFORMATION

You have the right to request an amendment to your Protected Health Information by completing this form and sending it to:

MEDICAL RECORDS DEPARTMENT
The Reading Hospital and Medical Center
PO Box 16052
Reading, PA 19612-6052

PLEASE PRINT

Your Name: _____ Date of Birth: _____
month day year

Home Address: _____
_____
_____

Please explain how the entry in your medical record is incorrect or incomplete.

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I understand that by listing the names and addresses of other organizations on this Amendment form, I am asking The Reading Hospital and Medical Center to take reasonable steps to disclose the requested amendment to these organizations. I therefore give specific permission to The Reading Hospital and Medical Center to disclose the amendment to these organizations.

PLEASE SPECIFY THOSE ORGANIZATIONS ON PAGE 2 OF THIS FORM

In addition, I understand that The Reading Hospital and Medical Center may be required to send this amendment to its business associates and other organizations that need to know about this amendment. I give specific permission to send the requested amendment to those organizations identified by The Reading Hospital and Medical Center as needing the amendment.

REQUEST TO AMEND PROTECTED HEALTH INFORMATION

THESE ARE THE ORGANIZATIONS THAT I WANT TO BE INFORMED OF THE REQUESTED AMENDMENT:

Name/Address: _____

Name/Address: _____

Name/Address: _____

Name/Address: _____

Note: If you have additional names, please attach an additional sheet to this page.

My signature below signifies that I fully acknowledge and agree to the above terms.

X _____ _____ _____

PATIENT SIGNATURE OR AUTHORIZED REPRESENTATIVE | DATE | PRINT PATIENT NAME

FOR OFFICE USE ONLY

MRN _____

Date received _____ Department _____ Received by (print) _____

☐ Approved ☐ Partial Approval ☐ Denied

If denied or accepted in part, check reason(s) for denial:

☐ PHI was not created by this organization

☐ PHI is not part of patient's designated record set

☐ The patient's record is accurate to the standard of reasonable accuracy as defined by Section 164.516 of the federal regulations.

☐ Other: _____

Comments: _____

Date Reviewed _____ Reviewed by (print) _____

Signature: _____

☐ Review requested?

Date Review received _____ Date Review processed _____

☐ Affirm Decision ☐ Overturn Decision

Patient notified _____

Comments: _____

Date Reviewed _____ Reviewed by (print) _____

Signature: _____