PALOS HOSPITAL / PALOS MEDICAL GROUP
PATIENT REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION

You have the right to ask Palos Hospital (PH) to amend protected health information (PHI) contained in your medical record. While we are not required to make the requested amendment in every case, your request will be reviewed carefully, and you will be notified within sixty (60) days whether your request is approved or denied or if PH needs a thirty (30) day extension to be able to act upon your request. To make such a request, please complete the following:

Last Name _____ First Name _____ Middle Initial _____

Address _____ City _____ State _____

Zip _____ Phone _____ DOB _____

Describe the reason for the requested change, the record type, and the date of the inaccurate entry:

_____

_____

_____

_____

_____

If you are aware of any other person(s)/entity (for example, physicians or another hospital) that may have a copy of the medical record you seek to have amended, please list the names and addresses here:

_____

_____

_____

_____

_____

By signing below, you hereby authorize PH to notify the persons/entities listed above to provide them with the amended information. You understand that you may be required to provide PH with a signed Authorization before PH will notify these person(s)/entity.

_____ _____

Signature Patient / Legal Representative* Date

*Describe scope of authority to act for patient _____ Day Phone: _____

SEND REQUEST FOR AMENDMENT TO: **Health Information Management**
Palos Hospital
12251 S. 80th Avenue
Palos Heights, IL 60463

☐ YOUR REQUEST FOR AN AMENDMENT HAS BEEN **ACCEPTED**.

Your Request for Amendment has been accepted, and an amendment will be made by either appending the records or providing a link to the amendment location. We are now in the process of notifying the persons and/or entities you identified above as having a copy of the medical record you asked to be amended.

☐ YOUR REQUEST FOR AN AMENDMENT HAS BEEN **DENIED**.

The reason for the denial:

- ☐ The health information was not created by PH.
- ☐ The health information is not part of the patient's medical record.
- ☐ The health information is not available for inspection under federal law (specifically, under 45 C.F.R. § 164.524).
- ☐ The health information in the patient's medical record is accurate and complete.
- ☐ Other reason: _____

STATEMENT OF DISAGREEMENT

If you do not agree with our decision to deny the requested amendment, you have the right to submit a written Statement of Disagreement explaining the reasons for your disagreement. However, we reserve the right to prepare a response to your Statement of Disagreement called a "Rebuttal Statement," which may be included in the relevant records along with your Request for Amendment and Statement of Disagreement. If you do not submit a Statement of Disagreement, you may still request that we include your Request for Amendment and its denial (or an accurate summary of such information) with any future disclosures of the PHI that is the subject of the amendment request.

If you wish to submit a Statement of Disagreement, send it to:

Health Information Management
Palos Hospital
12251 S 80th Avenue
Palos Heights, IL 60463

You may also file a complaint by contacting PH Patient Advocate Line at 708-923-4725 and/or file a complaint with the Secretary of the Department of Health and Human Services (HHS). Information on how to file a complaint with the Secretary of HHS may be found on the website of HHS' Office for Civil Rights at www.hhs.gov/ocr/hipaa.

Please check one of the following options:

☐ Statement of Disagreement submitted and will be included with future disclosures.

☐ Statement of Disagreement not submitted, but I wish to have the Amendment Request and Denial Notice included in future disclosures.

☐ Statement of Disagreement not submitted, and I do not wish to have the Amendment Request and Denial Notice included in future disclosures.

SIGNED: _____ DATE _____

Relationship to Patient: _____ Phone: _____

Office Use Only:

☐ Your request for an amendment could not be processed within 60 days and an extension of 30 days to _____ is needed because: _____

Signed: _____ *Title:* _____ *Date:* _____

☐ The requesting individual has been informed of the decision by copy of this form. ***Initial & Date*** _____

☐ The request was accepted and an amendment has been made by appending the records or providing a link to the amendment location. ***Initial & Date*** _____

☐ A Rebuttal Statement was provided to the individual requesting the amendment. ***Initial & Date*** _____

☐ If the request was denied, a copy of the Request for Amendment, Denial Notice, Statement of Disagreement, if any, and Rebuttal Statement, if any, has been placed in the records. ***Initial & Date*** _____