OSF Healthcare Saint James-John W. Albrect Medical Center
REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION (PHI)

To our Patients: Please complete this form if you or your authorized representative believe that there is certain incorrect or incomplete information in your Protected Health Information (PHI) records that we maintain. You or your authorized representative may request an amendment of your records in our facility. Our facility has 60 days to respond to your request. The facility is also allowed one 30-day extension to respond to your request. We will advise you in writing if an extension of time is needed. If your request is denied, we will notify you in writing of the denial reason and your rights to respond to the denial to amend your record.

Please complete the following:

Patient Name ______________________ Daytime Phone Number ( ) ______________________

Street Address ______________________ City, State, Zip Code ______________________

Patient Date of Birth ______________________

Name on Patient Record, if not same as above: ______________________

Please specify the records you are requesting an amendment to:

Date (if applicable) From ______________________ To ______________________

Amendment Requested (please be specific about what you believe is in error, or incomplete and what you believe the correct information should be): ______________________

____

____

The requested amendment should be shared with the following individuals or organizations (Please include ***complete*** physician or facility name for proper identification): ______________________

____

Please sign and date:

I request an amendment to my records as specified above. I understand that I will be advised in writing whether or not my request will be granted, and if denied, will be provided the reason for denial. If the amendment is accepted, I understand that OSF will also forward the amendment to other entities (besides the ones that I have named above) that OSF believes may rely on the PHI being amended (as indicated above). If the amendment request is denied, I understand that I will be advised of the reason for the denial, and that I may respond to the denial of the request for amendment.

Patient's Signature: ______________________ **Date:** ______________________

(If this request is signed by a Personal Representative on behalf of the individual, complete the following.

Pt. Representative's Printed Name: ______________________ **Date:** ______________________

Pt. Representative's Signature: ______________________ **Date:** ______________________

Relationship to Patient: ______________________

Please return this form to: ***OSF Healthcare Saint James-John W. Albrect Medical Center***
Medical Records
2500 W. Reynolds Street
Pontiac, IL 61764

OSF Healthcare Saint James-John W. Albrect Medical Center
REQUEST FOR AMENDMENT OF
PROTECTED HEALTH INFORMATION (PHI)