St. Elizabeth HEALTHCARE

Request to Amend Protected Health Information (PHI)

Please fill in the following information:

1. Your name: _____
2. Your mailing address: _____
3. Patient name (if different) _____
4. Patient Birth date_____ 5. Patient # _____
6. If you are not the patient, your relationship to the patient: _____
7. Describe the information you want to amend (e.g., lab test results, physician notes)

   _____
8. Applicable Date(s) of service _____
9. Reason for this request? _____

   _____

   _____

   _____
10. Do you know of anyone who may have received or relied on the information you want to amend (such as your family doctor, pharmacist, health plan, or other health care provider)?
    [ ] yes [ ] no If yes, please give the name(s) and address(s) of the organization(s) or individual(s). _____

    _____
11. Do you specifically authorize us to notify the person(s) listed in question 10, and any other persons or entities with whom we may have shared the information to be amended, of any amendment that is made to your health information as a result of this request? [ ] yes[ ] no

Signature of patient or legal representative_____Date _____

Submit this request to: HIPAA Privacy Officer, c/o St. Elizabeth Healthcare, 1 Medical Village Drive, Edgewood, KY 41017. You will receive a written response from us within 60 calendar days of our receipt of your request. (See the reverse side for our response.) In a very few circumstances, we may need an additional 30 days to respond to a request for amendment beyond the 60 day period. If that happens in your case, we will send you a written notice before the 60 days expire to inform you that we will need the additional 30 days to respond. If your request for amendment is denied, you will receive a written reason for the denial and we will explain your rights to have the denial decision reviewed and/or your right to submit a written statement of disagreement that can be included in future disclosures.

St. Elizabeth HEALTHCARE

RESPONSE TO REQUEST TO AMEND PROTECTED HEALTH INFORMATION

Your requested amendment (see reverse side) has been: [ ] Accepted [ ] Denied

If accepted, date amendment is included in the health information record:_____.
Date that authorized persons were notified of record amendment:_____.

If denied, your request was denied for the following reason(s):

[ ] The Personal Health Information (PHI) that you requested us to amend was not created by our organization and the organization or individual who created the PHI must make the decision to amend. Please contact the organization or individual that created the PHI that you wish to amend.

[ ] The PHI that you requested us to amend is not part of the patient's designated record set. In accordance with the federal regulations, only information that is part of the designated record set is subject to amendment.

[ ] The PHI that you requested us to amend is accurate and complete.

Staff comments _____
_____

Signature of authorized person _____
Date of decision: _____
Print name & title: _____

Your Rights Upon Receipt of a Denial

If your request for amendment was denied, you may exercise the following rights:

[ ] You may submit a written statement of disagreement (not to exceed 1-page in length) that will be included with the unchanged health information in any future disclosure. If you submit such a statement, we have the right under the regulations to prepare a rebuttal answer to your statement and we would include our answer along with your statement in any future disclosures. We are required to provide you a copy of our rebuttal answer, if we decide to create one.

[ ] If you decide to not submit a statement of disagreement, you may direct us to include your amendment request and this denial response with the unchanged health information in any future disclosures or use of the information. "Include my amendment request and your response in future disclosures of this information."

[ ] If you believe that we have not followed our information privacy policies or the federal regulations, you may file a complaint by contacting the ***Corporate Compliance Officer c/o St. Elizabeth Healthcare, 1 Medical Village Drive, Edgewood, KY 41017*** or the U.S. Department of Health and Human Services Office for Civil Rights at 200 Independence Avenue, S.W. Room 509F, HHH Building, Washington, D.C. 20201.

Signature of Patient/Requester: _____

Date: _____

To notify us of which of the above rights you wish to exercise:

- **Check the appropriate box above**
- **Submitting a written complaint or statement (if applicable)**
- **Sign this form**

If you do not wish to exercise any of these rights, retain this form for your records.

Please return a copy of this form to: HIPAA Privacy Officer, c/o St. Elizabeth Healthcare, 1 Medical Village Drive, Edgewood, KY 41017