Beaufort Memorial HOSPITAL

Request for Correction/Amendment of Health Information

Date of Request: _____

Patient's Name: _____ Date of Birth: _____

Medical Record #: _____ Account #: _____ Telephone #: _____

Address: _____

Date of Entry to be amended: _____ Type of Entry to be amended: _____

Reason for the Request:

_____

_____

_____

Would you like this amendment sent to anyone to whom we may have disclosed the information in the past. If so, please specify the name and address of the organization or individual:

Name: _____ Address: _____

_____ _____

Signature of Patient or Legal Representative ____ Date

FOR ORGANIZATION USE ONLY: Date Received: _____

Amendment has been: ☐ Accepted ☐ Denied

If denied, check reason for denial:

- ☐ PHI not created by this organization.
- ☐ PHI is not available to the patient for inspection as required by the federal law
- ☐ PHI is not part of patient's designated record set
- ☐ PHI is accurate and complete as originally documented
- ☐ Other

Comment: _____

_____

Name/Title of Staff Member Date

_____ _____

Signature of Healthcare Provider Date

** If you disagree with the provider, you may submit a written statement of disagreement. **

Revision date: 4/2022