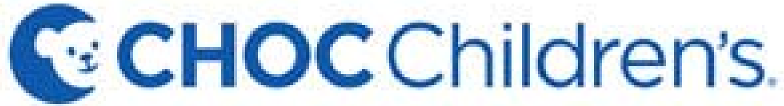

Request to Amend Protected Health Information

Date: ______ / _______ / _________

Patient name: ____

Date of birth: ______ / _______ / _________

Please tell us what protected health information you want changed:

____

____

____

____

Please tell us why you want this change. You must give a reason:

____

____

____

____

NOTE: We cannot delete or destroy any information already included in your medical record. We can only add clarifying or correcting statements.

We must tell you within 60 days if we will change your protected health information as you requested, or tell you that we need more time (up to 30 extra days) to decide.

Please tell us where to send your letter:

____

____

Please give a phone number in case we need to call you: _______________

If we decide to change the health information as you requested, we will send the change to any person who received the information before it was changed. Please tell us if there are any such persons who need the changed information:

☐ No Initials: ________ ☐ Yes Initials: ________

Please list the persons' names and addresses:

____

____

____

We will also send the amendment to other persons that we know received the information before it was amended if they relied, or might in the future rely, on the information to your detriment (harm). Do you agree to this?

☐ No Initials: ________ ☐ Yes Initials: ________

We do not have to change your protected health information if:

1. We did not create the information, unless the person who created the information is unavailable to act on your request to change it (for example, the doctor who originally created the information has died). If this exception applies to you, please explain:

   ____

   ____

2. The information is accurate and complete.
3. You do not have the legal right to access the protected health information you want changed.
4. The protected health information you want changed is not part of the designated record set. This includes your medical records, billing

records, and records containing your protected health information that are used by us to make decisions about you.

Date: _______ / ________ / __________ Time: ____________________AM/PM

Signature: ____

(patient/legal representative)

If signed by someone other than the patient, please indicate the relationship: ____

Print name: ____

(legal representative)

For more information about your privacy rights, see the "Notice of Privacy Practices" available on our website at www.choc.org or by sending a written request to:

CHOC Children's
Attn: Health Information Management Director
1201 West La Veta Avenue
Orange, CA 92868

If you believe your privacy rights have been violated, you may file a complaint with the hospital or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with the hospital, please call the compliance hotline at 877-388-8588. *You will not be penalized for filing a complaint.*

When you have finished filling out this form, please send it or bring it to:

CHOC Children's

Attn: Health Information Management Department
1201 West La Veta Avenue
Orange, CA 92868