Request for Correction or Amendment of Protected Health Information

Patient Name: Birthdate:

Medical Record #:

Patient Address:

Date of entry to be amended:

Type of entry to be amended:

Please explain how the entry is incorrect or incomplete. What should the entry say to be more accurate or complete?

Would you like the amendment sent to anyone to whom we may have disclosed the information in the past? If so, please specify the name(s) and address(es) of the organization(s) or individual(s). Please attach a separate sheet if necessary.

Name: Address (Street/City/State/Zip)

Signature of Patient or Legal Representative:

Date:

Submit completed form by fax (216) 778-8777, email to HIPAAPrivacy@metrohealth.org or mail to: The MetroHealth System, Ethics and Compliance Department, 2500 MetroHealth Dr., Cleveland, Ohio 44109

For The MetroHealth System use only:

Date Received:

Amendment has been:

☐ Accepted ☐ Denied

If denied, check the reason for denial:

☐ PHI was not created by this organization

☐ PHI is not part of a patient's designated record set

☐ PHI is not available to the patient for inspection as required by federal law (e.g., information compiled in anticipation of a legal proceeding)

☐ PHI is accurate and complete

Comments of Healthcare Practitioner:

Name of Healthcare Practitioner (Print): Title:

Signature of Healthcare Practitioner: Date: