MetroHealth

REQUEST FOR CORRECTION OR AMENDMENT OF PROTECTED HEALTH INFORMATION

1. Patient Information

LAST NAME	FIRST	MIDDLE	MAIDEN / OTHER NAME(S)	MH MEDICAL RECORD #

CURRENT ADDRESS	CITY	STATE	ZIP

DATE OF BIRTH (mm/dd/yy)	LAST 4 DIGITS SOCIAL SECURITY #	PHONE #	EMAIL ADDRESS

2. Amendment Information

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?

_____

3. Actions to take

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) 778-2413, email to: ReleaseofInformation@metrohealth.org or mail to: The MetroHealth System, Health Information Management Department G-108, 2500 MetroHealth Dr., Cleveland, Ohio 44109

4. 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

Name of Healthcare Practitioner (Print):_____ **Title:**_____

Signature of Healthcare Practitioner:_____ **Date**: _____

Comments: _____