REQUEST FOR AMENDMENT OF HEALTH INFORMATION

Please complete the following information:

1. Today's Date: _____

2. Patient's Full Name: _____

3. Birth Date: _____ 4. Patient #: _____

5. Patient Street Address: _____

   City: _____ State: _____ Zip:_____

6. Describe the information you want amended:

- ❑ Physician Note
- ❑ Nurses Note
- ❑ Healthcare Provider Note
- ❑ Prescription Information
- ❑ Patient History
- ❑ Lab Test
- ❑ Other _____

7. Date(s) of entry to be amended: _____

8. What is your reason for making this request?_____

9. How is the entry incorrect or incomplete? _____

10. Attach written Amendment and specify what the entry should say to be more accurate or complete. _____
    _____

11. Do you know of anyone who may have received or relied on the information in question (such as your doctor, pharmacist, health plan, or other health care provider)? _____
    _____

Please send completed request to: Department of Legal Affairs re: Medical Record Amendment

*If your request has been denied, in whole or in part, you have the right to submit a written Statement of Disagreement with the denial. *Attn: Nicole Kovolenko, Privacy Officer, c/o Patient Relations, The Valley Hospital, 223 North Van Dien Avenue, Ridgewood, New Jersey 07450.* If you do not provide us with a Statement of Disagreement, you may request that we provide your original request for amendment and our denial with any future disclosures of the protected health

information that is the subject of the requested amendment. Additionally, you may file a complaint with our *Privacy Officer, Nicole Kovolenko, at (201) 291-6329* or the Secretary of the U.S. Department of Health & Human Services.

If Amendment is accepted, do we have your permission to share amendment with individuals who have received this information?

- ❑ Yes
- ❑ No

Signature of patient/legal representative: _____ Date:_____

Individual other than patient: _____

Relationship to patient: _____ Date:_____

FOR HEALTHCARE ORGANIZATION USE ONLY

Amendment has been:

- ❑ Accepted
- ❑ Denied
- ❑ Denied in part, Accepted in part

If denied (in whole or in part)*, check reason for denial:

- ❑ PHI was not created by this organization
- ❑ PHI is not available to the patient for inspection in accordance with the law.
- ❑ PHI is not a part of patient's designated record set.
- ❑ PHI is accurate and complete.

Comments from healthcare provider who provided service: _____

_____

_____

_____

Name of Person Completing Form: _____

Title: _____ Date: _____

_____ Date:_____

Signature of Healthcare Provider Who Provided Service

- ❑ Patient has <u>not</u> filed a Statement of Disagreement, but requests that any future releases include the requested amendment and denial information.
- ❑ Patient <u>has</u> filed a Statement of Disagreement that **must** be released along with other documentation with any future releases of information.
- ❑ Facility/provider appended written response (rebuttal) and forwarded to patient.
- ❑ Facility/provider did not provide a response/rebuttal.

***THE HOSPITAL MUST INFORM PATIENT THAT A WRITTEN REQUEST IS REQUIRED, AND THAT THE PATIENT IS REQUIRED TO PROVIDE A REASON TO SUPPORT THE REQUESTED CHANGE.**