Pediatric Associates
33 Mollison Way
Lewiston, ME 04240

REQUEST FOR AMENDMENT TO PHI

Request for Correction/Amendment of Health Information

You have the right to request an amendment to your protected health information. If you would like to request an amendment to your protected health information, please complete the form below and hand it to the Privacy Officer.

Patient Name: _____Date of Birth:_____
Patient Number:_____
Patient Address:_____
Date of amendment request:_____

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

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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(s) or individual(s).

Name/Address:_____
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Name/Address:_____
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Name/
Address:_____
_____
_____
Note: If you have additional names, please attach an additional sheet to this page.

I understand that by listing the name(s) and address(es) of other organizations on this Amendment form, I am asking PEDIATRICS ASSOCIATES OF LEWISTON, P.A. to disclose the requested amendment to these organizations. I therefore give specific permission to PEDIATRICS ASSOCIATES OF LEWISTON, P.A. to disclose the amendment to these organizations, and I understand that PEDIATRICS ASSOCIATES OF LEWISTON, P.A. will take reasonable steps to send the requested amendment to these organizations.

In addition, I understand PEDIATRICS ASSOCIATES OF LEWISTON, P.A. may be required to send this amendment to Business Associates or other organizations that PEDIATRICS ASSOCIATES OF LEWISTON, P.A. identifies as needing the amendment. I therefore give specific permission to PEDIATRICS ASSOCIATES OF LEWISTON, P.A. to send the requested amendment to these organizations identified by PEDIATRICS ASSOCIATES OF LEWISTON, P.A. as needing the amendment.
I further understand that it is my responsibility to identify any originator(s) of my protected health information who may be no longer available to act on this amendment request, and present to PEDIATRICS ASSOCIATES OF LEWISTON, P.A. evidence that I have attempted to contact the originator(s). If I cannot present evidence of my attempts, PEDIATRICS ASSOCIATES OF LEWISTON, P.A. may deny the amendment request.

By signing below, I fully acknowledge and agree to the above terms.

_____
Signature of Patient

_____
Date

FOR OFFICE USE **ONLY**

Date Amendment Received:_____
Amendment Reviewed by: _____
Amendment has been: [ ] Accepted [ ] Accepted in part [ ] Denied

If denied or accepted in part, check reason(s) for denial:

[ ] PHI was not created by this organization
[ ] PHI is not part of patient's designated record set
[ ] The patient's record is accurate to the standard of reasonable accuracy as defined by Section 164.516 of the federal regulations.
[ ]
Other:_____
_____
_____

Comments of Healthcare Practitioner or
Reviewer:_____
_____
_____
_____

_____ _____
Signature of Reviewer Date Date

Has patient asked for a review of the decision?
[ ] Yes, letter asking for review received on _____.

Decision reviewed on _____by _____.

Reviewing official's decision:
[ ] Affirm decision [ ] Overturn decision (complete the disclosure information above).

Patient notified of reviewing official's decision in letter/fax sent on
_____.

_____
Reviewing Official's Signature
_____
Date

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