EVMS Medical Group

AMENDMENT OF PROTECTED HEALTH INFORMATION REQUEST FORM

As required by the Health Insurance Portability and Accountability Act of 1996 you have a right to request that health information pertaining to you be amended if you believe that it is incorrect or incomplete. EVMS Medical Group _____ will review your request and
Department
either grant your request or explain the reason why it will not be granted. In the event that your request is not granted you have the right to submit a statement of disagreement that will accompany the information in question for all future disclosures.

AMENDMENT REQUEST SECTION

I, _____ hereby request that the following
Patient Name and Date of Birth
health information pertaining to me be amended (*describe the information that you believe is incorrect or incomplete*):

I believe that the information that you currently have on file is incomplete or incorrect for the following reasons:

I believe that the correct information is as follows:

Additionally, I request that the following people be notified of the correction:

_____ _____

Signature *Date*

NOTE: If this request for amendment is denied, you may append a written statement of disagreement by completing the appropriate section of this form. You may also request that this form be included with any subsequent disclosures by initialing the appropriate line in the section reserved for statements of disagreement.

You may also register a formal complaint by contacting our Privacy Office: 757-451-6298 or writing to: EVMS Medical Group, Privacy Office, 4111 Monarch Way, Suite 500, Norfolk, VA 23508.

REVIEW SECTION

Date Request Received:	**Date Request Reviewed:**	**Date Patient Contacted:**
Request Received by:	**Request Reviewed by:**	**Patient Contacted by:**

This request to change health information is:

☐ Granted; changes made as follows:_____

_____

☐ Denied; information is accurate and complete as is.
☐ Denied; information did not originate here
☐ Denied; information is not part of designated record set
☐ Denied; information is not available for inspection

Reviewer's Comments:

_____ _____

Signature *Date*

STATEMENT OF DISAGREEMENT SECTION

_____ (initial) I wish for this request for amendment to be included with all future disclosures of the health information in question.

I disagree with the stated reason for denial and my reasons for disagreement are as follows:

_____ _____

Signature *Date*

REBUTTAL: (Office Use only)

_____

_____

_____ _____

Provider Signature *Date*