For National Jewish Internal Use Only: Date Received: _____

# REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION

BEFORE COMPLETING THIS FORM, PLEASE NOTE: Amending the medical record does not mean that the original entry will be altered or deleted; a separate entry may be made to correct or clarify the original entry. Requests will be fulfilled within 60 days unless an extension is needed per regulations.

PATIENT NAME: _____
First MI Last Maiden or Other Name

DATE OF BIRTH: _____ MEDICAL RECORD #: _____
MM/DD/ YYYY

ADDRESS: _____
Street City State Zip

PHONE NUMBER: _____ EMAIL ADDRESS: _____

***PLEASE ATTACH A COPY OF THE MEDICAL RECORD DOCUMENT(S) YOU ARE REQUESTING TO BE AMENDED.***
**PLEASE MARK ON THE DOCUMENT SPECIFIC WORDING YOU WOULD LIKE CHANGED.**

Date(s) of Service: _____
Clinician(s) of Record: _____
Describe what document or information you would like to be considered for amendment (radiology report, clinical visit note, procedure note): _____

Describe why the text you identified in the medical record is incorrect and how you are requesting the entry to be amended.: _____

***Please provide additional details on an attachment as needed.***

If granted, would you like us to notify persons/ organizations who may have previously received this information? If so, please specify the name(s) and address(es) below. If additional space is needed, please attach a form with the additional names and addresses.

| Name of Person or Entity | Address |
|---|---|
| | |
| | |
| | |

My treatment, payment, enrollment or eligibility for benefits may not be conditioned by signing below. This request is made voluntarily and the information given is accurate to the best of my knowledge. I may revoke this authorization at any time in writing, but if I do, it will have no effect on actions taken prior to receiving the revocation. I understand that information disclosed pursuant to the authorization may be subject to disclosure by the recipient and is no longer protected by the HIPAA privacy.

**Date** **Time** **Signature of Patient or Authorized Representative**

If signed by Authorized Representative:
Printed Name: _____State how Authorized: □ Legal Guardian □ Medical Durable Power of Attorney □ Parent of Minor □ Power of Attorney □ Proxy Decision Maker □ Other: _____

**Please complete and submit this form to: *Fax: 303-398-1211***
***Postal Mail: National Jewish Health, HIM Dept., L07 1400 Jackson ST Denver, CO 80206***

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Breathing Science is Life.®

HIPAA Patient Request _CC