Patient Request for Amendment of Protected Health Information **Form 7.80**

I, the undersigned, am requesting an amendment to my protected health information maintained by _____. I understand that this request may be accepted or denied. I also understand that if my request is accepted the following actions may occur:

- I will be informed of the amendment's acceptance;
- Any applicable original information will still remain in my record with the requested amendment or amended information;
- I may authorize a notification of the amendment to be sent to persons or entities identified by me; and
- A copy of the amended information may be sent to entities that could be predicted to use the original information in a detrimental manner.

If my request is denied, the following actions may occur:

- I will be provided with a written denial explaining the reason for the denial;
- I can submit a disagreement to the denial stating my reasons for disagreeing; and
- I may receive a response (rebuttal) to my disagreement.

I understand that a copy of this request, a copy of an acceptance or denial, a copy of any disagreement, and any rebuttal will become a permanent part of my medical record along with the original information I sought to amend.

_____

patient name

_____ _____

patient signature date

Requested Amendment

I request the following amendment to information in my medical record:

_____

_____

_____

_____

_____

_____

_____

_____

Please continue on the back of this form if necessary.