OSF Healthcare Holy Family Medical Center
REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION (PHI)

To our Patients: Please complete this form if you or your authorized representative believe that there is certain incorrect or incomplete information in your Protected Health Information (PHI) records that we maintain. You or your authorized representative may request an amendment of your records in our facility. Our facility has 60 days to respond to your request. The facility is also allowed one 30-day extension to respond to your request. We will advise you in writing if an extension of time is needed. If your request is denied, we will notify you in writing of the denial reason and your rights to respond to the denial to amend your record.

Please complete the following:

Patient Name _____ Daytime Phone Number ( ) _____

Street Address _____ City, State, Zip Code _____

Patient Date of Birth _____

Name on Patient Record, if not same as above: _____

Please specify the records you are requesting an amendment to:

Date (if applicable) From _____ To _____

Amendment Requested (please be specific about what you believe is in error, or incomplete and what you believe the correct information should be): _____

_____

_____

The requested amendment should be shared with the following individuals or organizations (Please include ***complete*** physician or facility name for proper identification): _____

_____

Please sign and date:

I request an amendment to my records as specified above. I understand that I will be advised in writing whether or not my request will be granted, and if denied, will be provided the reason for denial. If the amendment is accepted, I understand that OSF will also forward the amendment to other entities (besides the ones that I have named above) that OSF believes may rely on the PHI being amended (as indicated above). If the amendment request is denied, I understand that I will be advised of the reason for the denial, and that I may respond to the denial of the request for amendment.

Patient's Signature: _____ **Date:** _____

(*If this request is signed by a Personal Representative on behalf of the individual, complete the following.*

Pt. Representative's Printed Name: _____ **Date:** _____

Pt. Representative's Signature: _____ **Date:** _____

Relationship to Patient: _____

Please return this form to: ***OSF Healthcare Holy Family Medical Center***
Medical Records
1000 W. Harlem Avenue
Monmouth, IL 61462