OSU MEDICINE

REQUEST FOR CORRECTION/AMENDMENT OF PROTECTED HEALTH INFORMATION

Patient Name: _____

Address: _____

Medical Record #: _____ Date of Birth: _____

Requested Amendment

Date and Author of Entry to be Amended_____

_____

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

_____

_____

_____

Please provide the name and contact information for anyone who has received this information from OSU in the past if you would like OSU to send the amended information to such parties (if the amendment is accepted).

_____

_____

I understand that OSU Medicine may or may not amend the medical record as requested. Under no circumstances will OSU Medicine alter the original medical record. Regardless of the decision, this request will become a part of my permanent medical record.

Signature of Patient/Legal Representative _____ Date _____

Printed Name and Authority of Legal Representative (if applicable) _____

FOR OSU MEDICINE USE ONLY

Amendment has been: ☐ Accepted ☐ Denied ☐ Denied in part/Accepted in part

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

☐ PHI not created by this organization.

☐ PHI is not available to the patient for inspection in accordance with the law.

☐ PHI is not a part of patient's designated record set.

☐ PHI is accurate and complete.

Comments: _____

Date individual sent written denial: _____ Statement of Disagreement Received from Patient? ___ Yes ___ No

Compliance Reviewer: _____ Reviewing Provider: _____

Rev. July 2018