Amendment/Correction of Health Record Request

Name: _____ DOB/ID#: _____

Address: _____Phone#: _____ _

Date of Request: ____/___/_____

Please State What Needs To Be Amended / Corrected And Why:
Entry to be amended /corrected: _____ _

Date and author of entry: _____

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

_____

_____

_____

Would you like this amendment/correction sent to anyone to whom we may have disclosed this information in the past? If so, please specify the name and address of the individual(s) and/or organization(s):

_____

_____

_____

I understand that the City has sixty (60) days after receipt of this request to respond. In addition, the City may notify me in writing that an extension of up to thirty (30) days is needed.

_____
Signature of the Patient or Legal Representative Date

Date Received: ____/_____/_____ Accepted_____ Denied_____ Delayed _____

If denied, check reason for denial:
___PHI was not created by this organization
___PHI is not a part of the designated record set
___PHI is not available to the patient for inspection as permitted by federal law
___PHI is accurate and complete

Individual was informed in writing of the decision to accept or deny the request. (Attach correspondence)
Comments: _____
Staff Signature: _____ Date: ____/_____/_____

___Copy Sent to City Privacy Officer Date: ____/___/____

CITY OF LINCOLN NEBRASKA