Backus Hospital
A Hartford HealthCare Partner

REQUEST FOR AMENDMENT OF HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____ Contact Number: _____
Patient Address: _____
Date(s) of Entry to be amended: _____
Type of Entry to be amended: (Explain how entry is incorrect or incomplete. What should the entry say to be more complete)

_____
_____

Would you like this amendment sent to anyone to whom we may have disclosed the information in the past? If so please specify name and address of the organization or individual.

1) _____
2) _____

_____ _____
Name Address

_____ _____
Signature of Patient or Legal Representative Date

For Backus Hospital Only **Date Received:** _____

Amendment has been: **Accepted** ☐

I certify that the above information is correct to the best of my knowledge, and I have a good faith belief that the patient's health information is currently incorrect or incomplete in his/her medical record.

_____
Signature of Backus Hospital Provider Date/Time

Amendment has been: **Denied** ☐

If denied, check reason for denial:

☐ PHI was not created by Backus Hospital
☐ PHI is not available to the patient for inspection as required by federal law
☐ PHI is not part of the designated record set
☐ PHI is accurate and complete

_____
Signature of Backus Hospital Provider Date/Time

Comments of Backus Hospital

Amendment Inserted in Record ☐ Date:_____ ☐Original Record Revised & Amended Date:_____
Amendment Denial Inserted in Record ☐ Date: _____ ☐ Notification of Others Date: _____

Individual Informed Date: ☐ In Person _____ ☐ Telephone _____ ☐ Mail _____

_____ _____
Signature of HIM Staff Member Title/Date/Time

MRLEGAL