SAN ANTONIO REGIONAL HOSPITAL

REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION

Patient's Name _____
Last First Middle

Home Address _____
_____

Home Phone _____ Date of Birth _____

SS# _____-_____-_____ MRN# _____

Date of Service/Treatment _____

I hereby request that San Antonio Regional Hospital amend (please check all boxes that apply):

- ☐ My medical records
- ☐ My billing records
- ☐ My enrollment, payment, claims adjudication, case or medical management records
- ☐ My records used by or for San Antonio Regional Hospital to make decisions about me as more specifically defined below.

I understand that San Antonio Regional Hospital may deny this request as permitted under federal law. I further understand that if San Antonio Regional Hospital denies my request, I will be informed in writing by San Antonio Regional Hospital of its reason for the denial and what I should do if I disagree with the denial. I further understand that San Antonio Regional Hospital will notify me of its decision to accept or deny my request within sixty (60) days of receiving this request. If San Antonio Regional Hospital is unable to comply with my request within this time frame, I understand that it may extend the applicable deadline for up to an additional thirty (30) days by notifying me in writing. I further understand that this request and any decision regarding this request will be included in my medical record.

NOTE: We cannot delete or destroy any information already included in your medical record. We can only add clarifying or correcting statements.

1. Describe the information you want amended (e.g. procedures, nursing/physician notes, test results:

   _____
   _____
   _____
   _____

2. Date(s) of information to be amended (e.g. date of office visit, treatment, or other health care service).

_____
_____

3. What is your reason for making this request?

_____
_____
_____

4. How is the entry incorrect, incomplete, or outdated?

_____
_____
_____

5. What should the entry say to be more accurate or complete? (Please be as specific as possible)

_____
_____
_____
_____

6. Do you know of anyone who may have received or relied on the information in question (such as your doctor, pharmacist, health plan, or other health care provider)?

☐ Yes
☐ No

If yes, please specify the name(s) and address(es) of the organizations or individual(s).

_____
_____
_____
_____

_____ _____

Signature of Patient or Patient's Representative Date

FOR SAN ANTONIO REGIONAL HOSPITAL USE ONLY

Amendment has been:

- ☐ Accepted
- ☐ Denied

If denied, check the reason for denial:

- ☐ Protected Health Information was not created by this facility.
- ☐ Protected Health Information is not part of the patient's Designated Record Set.
- ☐ Protected Health Information is not accessible by the patient under San Antonio Regional Hospital's policy regarding patient's right to access his or her Protected Health Information.
- ☐ Protected Health Information is accurate and complete.

_____ _____

Signature of Health Care Provider Date

Additional Comments:

_____ _____

Signature of Privacy Officer Date