



Request for Amendment of Protected Health Information

Request Date: _____

Individual Name: _____ Date of Birth: _____ SSN: _____

Patient Address: _____

Telephone Number: (H) _____ (W) _____

Medical Record No. : _____

After review of my medical record, I am requesting that information on the following service date(s) _____ be amended/supplemented with certain information and added in the form of an addendum to my medical record. I am requesting this amendment because: _____

I understand that [St. Louis Children's at CoxHealth *member*] may or may not amend/supplement my medical record based on my request and under no circumstances, can [St. Louis Children's at CoxHealth *member*] alter the original documentation of my medical record.

Amendment Request:

I request the following amendment/supplement be made to my medical record:

Signature (Patient or Legal Representative): _____ Date: _____

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 healthcare provider)? ___Yes ___No

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

For [St. Louis Children's at CoxHealth] Use Only:

Amendment has been: ___Accepted ___Denied

- In response to your request, an amendment/supplement will be made part of your medical record.
- Your request has been denied for the following reasons: _____
- The information is accurate and complete.
- The information was not created by this [St. Louis Children's at CoxHealth member].
- The information is not part of the Designated Record Set.
- Federal law prohibits making the Information available to the patient for inspection (e.g. psychotherapy notes).
- Other: _____

Staff comments: _____

Signature of Staff person: _____ Date: _____

Print name & title: _____

Statement of Disagreement:

If you do not agree with the above, you may submit a Statement of Disagreement that will become part of your medical record and included in any future disclosure of the subject medical information. Please outline the reason for your disagreement in the space provided below: (may attach no more than 2 pages)

I do not wish to submit a Statement of Disagreement. However, I am requesting that [St. Louis Children's at CoxHealth *member*] include in any future disclosure my request for amendment form and [St. Louis Children's at CoxHealth *member*]'s denial

Signature (Patient or Legal Representative)

Date Forward or mail, postage pre-paid, this form to: [St. Louis Children's at CoxHealth *member*]