COMMUNITY HEALTH SERVICES
OF LAMOILLE VALLEY®

Request For Amendment/Correction of Protected Health Information

Name:		Request Date:	
Street Address:		Birth Date:	
City/State/Zip:		MR/Account #:	

WHAT NEEDS TO BE AMENDED/CORRECTED

Entry to be amended:	
Date & Author of Entry:	

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

If this amendment accepted, would you like this amendment sent to anyone to whom we may have disclosed this information in the past? If so, please specify the name and address of the organization or individual.
Name(s) & Address(s):

I understand that the provider may or may not amend the medical record based on my request, and under no circumstances is the provider permitted to alter the original medical record. In any event, this request for an amendment will be made part of my permanent medical record.

_____ _____ _____/_____/_____
Signature of Patient /Representative Print Name Date

FOR CHSLV INTERNAL USE ONLY

Date received: ____/_____/_____	❑ Amendment Accepted by CHSLV ❑ Amendment Completed ❑ Amendment Sent to Patient/Representative requested entities	❑ Amendment Request Denied

If denied, check reason for denial:

- ❑ PHI was not created by this organization
- ❑ PHI is not available to the individual for inspection as permitted by federal law (e.g., psychotherapy notes)
- ❑ PHI is not part of designated record set
- ❑ PHI is accurate and complete

- Notice of Decision Letter for Request to Amend PHI Letter was sent within 60 days (attach letter) Date Sent : ____/_____/____
  - Individual's Statement of Disagreement received (attach) □ Yes □ No
  - CHSLV Rebuttal Statement Letter Sent (attach) □ Yes □ No Date Sent : ____/_____/____

_____ Date:___/_____/_____
Signature of Primary Care Practitioner

_____ Date:___/_____/_____
Signature of Privacy & Security Officer