Reset

REQUEST FOR AMENDMENT/CORRECTION OF PROTECTED HEALTH INFORMATION

Name:		Date of Birth:
Street Address:		Phone Number:
City/State/Zip:		

WHAT INFORMATION NEEDS TO BE AMENDED/CORRECTED and FOR WHAT REASON?

Entry to be amended:	
Date(s) of entry:	
Author(s) of entry:	

Please explain how the information is incorrect or incomplete.

If this amendment is accepted, would you like it sent to anyone with whom we may have shared this information in the past? If yes, please specify the name, address, fax number, or secure email of each individual or organization.

I understand the provider may or may not amend the health information based on my request, and under no circumstances is the provider permitted to alter the original health information. This request for an amendment will be made part of my permanent record. If signed by a person other than the patient, please provide proof of legal authority.

_____ _____

Signature of Individual or Individual's Legal Representative Date

Relationship to Individual: _____

RETURN COMPLETED FORM TO:

Summa Health MyChart Amendment Support
Health Information Management – 1st Floor
141 N. Forge St.
Akron, OH 44304
FAX: 330.375.3392 PHONE: 330.375.4941