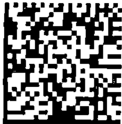

Catholic Health Services *of Long Island* At the heart of health

☐ GSH ☐ MMC ☐ SCH ☐ SCS
☐ SFH ☐ SJH ☐ PRACTICE

PATIENT REQUEST FOR AMENDMENT OF RECORDS

Amendment - SCAN, PATIENT AMENDMENT REQUEST, 4/13/15

You have the right to request that we amend your personal health information in our records. This information may be used to make decisions about you and your treatments for as long as we maintain it in our records. Please see our Notice of Privacy Practices for a more detailed description of your rights and the process we follow once we have received your request. To request an amendment to your health record, complete and return this form.

PATIENT INFORMATION

Patient Name: ____
Last First MI DOB

Address: ____

Telephone: (daytime) ______________________ (evening) ______________________

Please check the following: ☐ Hospital ☐ Practice ____________ Source: ☐ Copies of Record ☐ MyChart

AMENDMENT REQUEST

Please answer the following questions. You may attach a separate page if more space is needed.

Which information would you like to amend (e.g., __________, __________)? ______________________

How do you believe the information should be amended? ______________________

Why do you believe the information should be amended? Your request may be denied if you do not provide a reason to support your request. ______________________

Please indicate if the request needs to be expedited and reason for the request. We cannot guarantee that we will meet your deadline, but we will do our very best to accommodate reasonable requests.

PATIENT UNDERSTANDING AND SIGNATURE

By signing below, I am requesting that ______________________ (name of facility) amend my health information as I have explained above.

____
Signature of Patient or Personal Representative

____
Print Name of Patient or Personal Representative

____
Date

____
Description of Personal Representative's Authority

SEND COMPLETED FORM TO:

Contact Person or Department
HOSPITAL/PRACTICE
Street Address
City State Zip

FOR CHS USE ONLY:	Date Received: (MM/DD/YYYY) ______/______/______ Disposition of Request: ☐ Granted ☐ Denied ☐ Partially Denied Patient Notified in Writing on This Date: (MM/DD/YYYY) ______/______/______	Name of HIM Dept/Practice Staff Member Processing This Request:

HBG 33090 (4/13/15) 1.1

DO NOT WRITE IN THIS AREA

DO NOT WRITE IN THIS AREA