PHI Amendment Request

UnityPoint Health

REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION

Patient Name: _____
Last **First** **MI**

Home Address: _____

_____

Phone: _____ **Date of Birth:** _____

1. Indicate the type of record to be amended.

   _____Medical records

   _____Billing records

2. Describe the information you want amended (such as procedures, nursing/physician notes, test results). You may include a “mark-up” of your records.

   _____

   _____

   _____

   _____

3. State date(s) of information to be amended (such as date of office visit, treatment, admission, or other health care services).

   _____

   _____

   _____

   _____

UnityPoint Health

4. What is your reason for making this request?

_____

_____

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 How is the entry incorrect, incomplete, or outdated?

_____

_____

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

_____

_____

_____

7. 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 organization(s) or individual(s):

_____

_____

_____

_____

_____

By supplying this information, you agree that UnityPoint Health may send information to these individuals or organizations. UnityPoint Health may also send corrected records to other individuals or organizations that it knows has the information that is the subject of the amendment and that may have relied, or could foreseeably rely, on such information to your detriment.

8 **By signing below, I understand that UnityPoint Health may deny this request as permitted under law. I further understand that if UnityPoint Health denies my request, I will be informed in writing by UnityPoint Health its reason for the denial and what I should do if I disagree with the denial. I further understand that UnityPoint Health will notify me of its decision to accept or deny my request within sixty (60) calendar days of receiving this request. If UnityPoint Health 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) calendar days by notifying me in writing.**

_____

Signature of Patient or Patient's Personal Representative Date

Please return this form using the information below:

Via Email**:** **UPH_PrivacyOfficers@unitypoint.org**

If you prefer to mail your form, please use the below address:

UnityPoint Health
Attn: Privacy Officer
1776 West Lakes
Parkway Suite 400
West Des Moines, IA 50266

FOR UNITYPOINT HEALTH USE ONLY: **Patient MRN:**_____

Amendment has been ___Accepted ___Denied

If denied, check the reason for denial:

___Protected Health Information was not created by UnityPoint Health
___Protected Health Information is not part of the patient's Designated Record Set
___Protected Health Information is not accessible by the patient under UPH policy regarding the patient's right to access their Protected Health Information
___Protected Health Information is accurate and complete

Comments: _____

_____

Signature of Privacy Officer:_____ **Date:** _____