EXETER HOSPITAL
5 Alumni Drive Exeter, NH 03833 603.778.7311

Date Received:

REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION

This is a duplex form page 1 of 2. Additional Information on page 2

Patient Name: (Last, First, Middle)	**Birth Date:**	
Address	**Phone Number: ( ) -**	
City:	**State:**	**Zip**

Date(s) of service and record(s) requested to be amended:

Author or provider name responsible for the entry/documentation:

Please describe the information you want amended. What would you like to add/change to the record? (You may include copies of the information for reference or attach additional comments if needed)

If this amendment is accepted, would you like the amended information sent to anyone to whom we may have disclosed this information in the past? ☐ Yes ☐ No

If yes, please specify the name and address of the organization(s) or individual(s) below. Please print clearly.

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

_____ _____

Signature of Patient or Patient's Legal Representative Date

Pursuant to 45 CFR 164.526, your request will be processed within 60 days from the date received

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FOR HEALTHCARE ORGANIZATION/INTERNAL USE ONLY	
Patient Name:	Medical Record Number:
❑ Accepted	❑ Denied

If denied, check reason for denial below:

- ❑ Health information is accurate and complete
- ❑ Health information was not created by this organization
- ❑ Health information is not part of the patient's health record
- ❑ Federal law forbids making the health information in question available to the patient for inspection (e.g. psychotherapy notes)
- ❑ Originator of the record is not available because:_____

Staff Comments:

_____ _____

Signature and Title of Author/Provider Date