



Monroe Clinic

REQUEST FOR AMENDMENT/ CORRECTION OF PROTECTED HEALTH INFORMATION

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

WHAT NEEDS TO BE AMENDED/ CORRECTED AND WHY

Entry to be amended	
Date and Author of Entry	

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

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.

Names and addresses:

I understand that The Monroe Clinic may or may not amend the medical record with an amendment based on my request, and under 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 or Patient’s Legal Representative

Date

FOR THE MONROE CLINIC INTERNAL USE ONLY

Date Received:	<input type="checkbox"/> Accepted	<input type="checkbox"/> Denied
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If denied, check reason for denial:

<input type="checkbox"/> PHI was not created by The Monroe Clinic	<input type="checkbox"/> PHI is not part of patient’s designated record set
<input type="checkbox"/> PHI is not available to the patient due to Federal or State law	<input type="checkbox"/> PHI is accurate and complete

Comments:

Individual was informed of denial in writing (attach letter of communication)

Signature/ Title of The Monroe Clinic Staff Member

Date