Health
AUGUSTA UNIVERSITY

To request an amendment, complete and return this form to:
AU Medical Center
Medical Records BPM-210
1120 15th Street
Augusta, GA 30912

Request to Amend Protected Health Information

Patient Name:		Patient Number:
Date of Birth:	Phone:	Last four digits of Social Security Number:
Patient Address:		

Date of Entry to be amended: _____

Type of entry to be amended: _____

How is the entry incorrect or incomplete? _____

_____

_____

What should the entry say to be more accurate or complete?

_____

_____

Would you like this amendment sent to anyone to whom we may have disclosed the information in the past? If so, please specify the name and address of the organization(s) or individual(s).

Name(s)	Address(es)

<u>To our Patients/Personal Representatives</u>: You have the right to request an amendment to be made part of your health record. This request will not change or alter the original record created by your health care provider, but will supplement the record. We may deny your request to amend or correct your records. All decisions will be provide to you in writing within 60 days from receipt of your request.

_____

Signature of Patient or Legal Representative Date

** FOR AU HEALTH SYSTEM USE ONLY **

Date Received: _____ Amendment has been: ☐ Accepted ☐ Denied

If denied, check reason for denial:

☐ PHI was not created by this organization
☐ PHI is not part of patient's designated record set
☐ PHI is accurate and complete
☐ PHI is not available to the patient as required by federal law (e.g., psychotherapy notes)

Comments of Author or Responsible Practitioner: _____

_____

_____

Name of Responsible Practitioner: _____ Title: _____

Signature of Responsible Practitioner: _____ Date: _____

Denial Reviewed by: _____ Date: _____

Signature and Title:

PRIVCORR