



MR# / SSN: \_\_\_\_\_

**REQUEST FOR CORRECTION/AMENDMENT OF  
PROTECTED HEALTH INFORMATION**

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**Date of entry to be amended:** \_\_\_\_\_

**Type of entry to be amended:** \_\_\_\_\_

**Please explain how the entry is 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 or individual.**

\_\_\_\_\_  
**Name** **Address**

\_\_\_\_\_  
**Signature of Patient or Legally Qualified Representative** **Date**

.....  
*For Office Use Only*

**Date Received:** \_\_\_\_\_ **Amendment has been** \_\_\_ **Accepted** \_\_\_ **Denied**

**If Denied, Check reason for denial:**

- \_\_\_ **PHI was not created by Palmetto Health**
- \_\_\_ **PHI is accurate and complete**
- \_\_\_ **PHI is not part of the patient's designated record set**

**Department Name:** \_\_\_\_\_

**Name of Staff Member:** \_\_\_\_\_ **Title:** \_\_\_\_\_

**Comments of Healthcare Provider:**

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\_\_\_\_\_  
**Signature of Healthcare Provider**

\_\_\_\_\_  
**Date**