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REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION

Patient's Name: _____
Last First Middle

Home Address: _____

Home Phone: _____ Date of Birth: _____

Dates of Service: _____

Medical Record Number: _____

Check the location where you were treated:

Voorhees Pediatric Facility

Medical Day Care

Other: _____

I hereby request that above location amend [please check all boxes that apply]:

My medical records.

My billing records.

Any other records used to make decisions about me.

I understand that the facility above may deny this request as permitted under Federal law, and that I will be informed by the facility concerning the basis for the denial along with instructions concerning my right to submit a statement disagreeing with such denial. I further understand that the facility will notify me of its decision to accept or deny my request within sixty (60) days of receiving this request. If the facility 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) days by notifying me in writing.

I also understand that above named facility will contact my health care provider(s) involved in my care, if the amended information concerns my clinical treatment, while a patient at any of the above mentioned facilities.

1. Describe the information you want amended or added (e.g., procedures, provider notes / documentation, test results, medical/family/social history, diagnosis)

2. Date(s) of information to be amended (e.g., date of test, visit, treatment, or other health care services)

3. What is your reason for making this request?

4. How is the entry incorrect?

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

6. 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).

Printed name of Patient (or Personal Representative): _____

Relationship to Patient: _____

Please print and sign with blue or black ink.

Signature of Patient (or Personal Representative) _____ Date _____

Please submit the completed form via email, fax or mail:

Fax # 856-810-3747

Address to email: HIMROI@Weismanchildrens.com

Address to mail:

Health Information Management, 92 Brick Road, Marlton New Jersey 08053