Affix Patient Label

**BRONSON HEALTHCARE**
**REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION**

**Patient's Name:** ____________________________________________
Last First Middle

**Home Address:** ____________________________________________

____________________________________________

**Home Telephone:** ______________________ Date of Birth: ______________________

I hereby request that Bronson amend **[please check all boxes that apply]:**

☐ My medical records

☐ My billing records.

☐ My enrollment, payment, claims adjudication, case or medical management records.

☐ My records used by or for Bronson to make decisions about me.

I understand that Bronson may deny this request as permitted under federal law.

I understand that if Bronson denies my request, I will be informed in writing of the reason for the denial and what I should do if I disagree with the denial.

I further understand that Bronson will notify me of its decision to accept or deny my request within sixty (60) days of receiving this request. If Bronson 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.

1. Describe the information you want amended (e.g., procedures, nursing/physician notes, test results)
____________________________________________
____________________________________________
____________________________________________
____________________________________________

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

3. What is your reason for making this request?____________________________________________
____________________________________________

4. How is the entry incorrect, incomplete, or outdated?____________________________________________
____________________________________________
____________________________________________

5. What should the entry say to be more accurate or complete? (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 organizations or individuals(s).

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

Signature of patient or patient's Personal Representative___________________________________

Date________________________________

**FOR COMPANY USE ONLY**
Amendment has been: ___ Accepted ___ Denied

If denied, check the reason for denial:

___ Protected Health Information was not created by the Company
___ Protected Health Information is not part of the patient's Designated Record Set
___ Protected Health Information is not accessible by the patient under the Company's policy regarding the patient's right to access his or her Protected Health Information
___ Protected Health Information is accurate and complete

Comments ______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

Signature of Privacy Officer/Designee ______________________________________________________
Date _______________