Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION

Patient Name: Health Record Number:

Patient Address:

Phone #: (H) (W) DOB:

After review of my protected health information, I do not feel the original documentation is accurate for the following **service dates** and following **reasons:**

I understand that Kaiser Permanente may or may not supplement the protected health information with an addendum based on my request, and under no circumstances, is able to alter the original documentation of the protected health information. In any event, this request for an addendum will be made part of my permanent protected health information and will be sent as part of my designated record set in response to any authorized requests for my medical information.

I request the following correction/supplementation be made on my protected health information:

Would you like this amendment sent to anyone to whom we have disclosed this information in the past? If so, please specify the name and address of the organization or individuals (use backside if needed).

If you are 13–17 years old, you will need your parent's signature.

Signature of Patient or Legal Representative **Date**

Note: Verification of Authority to make request may be required.

For healthcare organization use only:

Date received: ❑ Amendment accepted ❑ Amendment denied

If denied, check reason for denial:

❑ PHI not created by this organization. ❑ PHI is not part of the patient's designated record set.

❑ PHI is accurate and complete.

❑ PHI is not available to the patient for inspection as required by state and/or federal law (e.g., psychotherapy notes).