KAISER PERMANENTE®

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 age 13-17, you will need your parent's signature.

_____ _____

Signature of Patient or Legal Representative **Date**

Note: Verification of Authority to make request may be required