



0049011

**ALBERT EINSTEIN HEALTHCARE NETWORK  
Request for Amendment of Protected Health Information**

Patient Label (Name and Medical Record #)

- AEMC     Ctr One     GCHS     MossRehab     Belmont     Willowcrest
- Other \_\_\_\_\_

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

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

**City, State, Zip Code:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_

I hereby request that the Albert Einstein Healthcare Network ("the Network") amend:

- My Medical Records
- My Billing Records
- My enrollment, payment, claims adjudication, case or medical management records
- My records used by or for the Network to make decisions about me.

Date of Information to be amended: (date of hospital visit, treatment, office visit, other healthcare services)


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

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2. What is your reason for making this request?

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3. How is the entry incorrect, incomplete, or outdated?

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4. What should the entry say to be more accurate or complete? (Please be as specific as possible. You may attach documentation to this form if needed)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. 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).

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I understand that the Network may deny this request as permitted under federal law. I further understand that if the Network denies my request, I will be informed in writing by the Network of its reason for the denial and what I should do if I disagree with the denial. I further understand that the Network will notify me of its decision to accept or deny my request within sixty (60) days of receiving this request. If the Network 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.

**Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature of Legal Guardian/Representative:** \_\_\_\_\_

**Relation to Patient:** \_\_\_\_\_

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