0049011

EINSTEIN HEALTHCARE NETWORK

REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION

Patient Label (Name and Medical Record #)

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)

_____

_____

_____

_____

_____

2. What is your reason for making this request?

_____

_____

_____

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 How is the entry incorrect, incomplete, or outdated?

_____

_____

_____

Patient Label (Name and Medical Record #)

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: _____