REQUEST FOR CORRECTION TO PERSONAL HEALTH INFORMATION

Information and Instructions

We will correct health record information if it is demonstrated, to our satisfaction, that the record is not correct or complete for the purpose for which we collect, use or disclose the information. We will make every effort to respond to your request in a timely fashion. Please complete Parts A and B of this Form and forward to Health Information Services.

PART A: REQUESTOR INFORMATION

Patient Contact information:

_____ _____ _____
Last Name First Name Initials

_____
Mailing Address

_____ _____
Telephone Number Date of birth

If you are a substitute decision-maker, your contact information:

_____ _____ _____
Last Name First Name Initials

_____
Mailing Address

_____
Telephone Number

Note: Include copies of documents that provide your authority as a substitute decision-maker.

PART B: CORRECTION REQUEST

1. List or attach the correct requested, with reasons for the correction.

Requested Correction	Reasons for Correction

2. How do you wish to receive notice of the correction (in writing, by telephone)?

_____

3. Would you like us to give notice of the correction, to the extent reasonably possible, to others to whom we have disclosed the incorrect information? (We will only do so if this notice will affect your health care or otherwise benefit you).

☐ Yes
☐ No