Patient Name (Last, First, Middle)**:** _____

Date of Birth: _____

Address (Please list address where OhioHealth can send response letter)**:**

Street address: _____

City: _____ State: _____ Zip: _____

Email address: _____ **Phone Number**: (____) _____

1. **Description of health information you are requesting to be amended:**

Date of Visit/Service	**Information Type** (Office visit, ER note, Procedure Note, etc.)	**Provider Name & Facility** (if known)

To review the requested amendment, we must be able to locate the record at issue and the exact entries and reports you want amended.

2. **What is your reason for making this request?**

_____

_____

_____

3. **How is the information incorrect, incomplete, or outdated?** *(Please include a highlighted copy of the page(s) from your medical record where this information shows as incorrect, incomplete, or outdated.)*

_____

_____

_____

4. **Please state as specifically as possible how you would like the information amended?** *(Please be as precise as possible and attach additional pages if necessary)*

_____

_____

_____

5. **Supporting documentation provided with form** *(i.e. highlighted copy of page(s) from medical record where information is incorrect, incomplete, or outdated):* ❒ Yes ❒ No

OhioHealth may accept or deny your request to amend as permitted under federal law. OhioHealth cannot amend documentation that was not originated in one of our facilities. If your request is denied, you will be informed in writing of the reason for the denial and what you should do if you disagree with the denial. You will be notified whether your request is accepted or denied within sixty (60) days of receipt of this request. OhioHealth can extend the response period for up to an additional thirty (30) days) by notifying you in writing.

_____ _____ _____

Signature of patient or patient's Personal Representative Date: Time:

Note: *If you need a copy of your medical records, you may receive a free copy upon the completion of an authorization for records form.*

PLEASE RETURN THIS FORM AND SUPPORTING DOCUMENTS TO ONE OF THE OPTIONS LISTED ON THE BACK.

OhioHealth

1AMEND

PATIENT IDENTIFICATION

REQUEST TO AMEND PROTECTED HEALTH INFORMATION

SEND THE FORM TO MAKE A CHANGE TO YOUR HOSPITAL RECORD

BY MAIL OR IN PERSON

Attn: Health Information Management Department
3535 Olentangy River Road
Columbus, OH 43214

EMAIL

HIM-PATIENT-AMENDMENT-REQUESTS@OhioHealth.com

Please call your doctor's office to find out where you need to send the form to change an office record.