CityMD
Part of VillageMD®

Patient Request: Amendment of Patient Health Information (PHI)

Purpose: To request correction of PHI maintained in medical records

Medical Group: _____
(name of practice)

Provider Name: _____

Please complete the following section (print clearly):

_____
Patient's Last Name First Name MI

_____
Patient Address (include complete mailing address)

_____
City State Zip Code

_____
Birth Date (Month/ Day/ Year)

_____
Last 4 of SSN or Medical Record Number (if known)

_____
Phone # Email Address

Request Details:

I here by request an amendment/correction of my Protected Health Information as indicated below (check all that apply):

☐ Medical Records ☐ Billing Records ☐ Other: _____

Please list information to be amended (specific reports, results, etc.): _____

_____

Please list date(s) of service/visit to be amended/corrected: _____

_____

Please explain why you want this change. **You must give a reason**: _____

_____

_____

Notification if Request is Granted:

We must tell you within 60 days if we will change your medical records as you requested, or tell you that we need more time (up to 30 extra days) to decide. Please tell us where to send you a letter:

_____

_____

_____

If we decide to change the health information as you requested, we will send the change to any person/entity who received the information before it was changed. Please tell us if there are any such persons who need the changed information:

☐ No. Initials: _____

☐ Yes. Please list the persons' names and addresses:

_____ _____

_____ _____

_____ _____

We may deny your request to change your PHI if:

1. CityMD (part of VillageMD) did not create the information.
2. CityMD (part of VillageMD) believes it to be accurate and complete.
3. You do not have the legal right to access the PHI you wanted changed.
4. The protected health information you want is not part of the designated record set. This includes your medical records, billing records, and records containing your PHI that are used by us to make decisions about you.

By signing this form, you hereby grant CityMD (part of VillageMD) to notify people of any accepted changes that are known to have your PHI and that may have relied on, or could possibly rely on, such information to the detriment of you.

Date:_____ Print Name: _____ Signature: _____

Please mail this form to the **Health Information Management (HIM) Department** **ATTN: Patient Amendments** at 1 Diamond Hill Rd, Berkeley Heights, NJ 07922 or email to patientamendments@summithealth.com.