anewhealth

Request for Amendment to PHI

Name of Individual: _____ Date of Birth: _____

Address: _____ Telephone: _____

_____

I am requesting that the healthcare provider amend my Protected Health Information ("PHI") or records as follows: *(please be specific and attach additional sheet if necessary)*

The reason for the requested amendment is as follows:

I authorize the healthcare Company to notify the following persons known to me as having received the disputed information: (*attach additional sheet if necessary)*

I understand that the healthcare Company will contact those persons identified by me (above) and any other persons that the healthcare Company is aware of possessing the information that is the subject of the amendment if the request for amendment is approved by the healthcare Company. The healthcare Company will send notification of the request approval or denial to me within sixty (60) days from the healthcare Company's receipt of this request unless the healthcare Company requests an extension.

Date: _____ Signature of Individual/Legal Representative: _____

Legal Representative's Authority: (Relationship to Individual) _____

You may file the completed request with the Healthcare Company or Mail to:

AnewHealth
ATTN: Privacy Officer
8333 Rockside Road
Valley View, OH 44125-6126

***Office Use Only* – Please Do Not Write Below This Space**

❒ **Approval Granted** ❒ **Approval Denied** ❒ **Notice Mailed to Individual**

Date Rec'd: _____ **Initials:** _____