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Patient Name: _____ Date of Birth _____ Phone: _____

Please select appropriate location of which you are requesting your PHI to be amended

- Mission Hospital Angel Medical Center Blue Ridge Regional Hospital CarePartners
- Highlands-Cashiers Hospital Mission Hospital McDowell Transylvania Regional Hospital
- Physician Practice _____ Other _____

Date(s) of Treatment: _____

Documentation type: _____

Describe the information you want changed: _____

What should the entry say to be more correct or complete? _____

If this amendment is approved, please identify anyone we may have disclosed the information to in the past who must be notified of the change. _____

I understand Mission Health must respond to my request within 60-days from date of receipt. Mission Health will notify me in writing if Mission Health accepts or denies this request. If Mission Health is unable to complete request within the 60-day period, Mission Health will notify me in writing of the delay. Mission Health will then have an additional 30 days to respond to request. If request is accepted, Mission Health will make appropriate amendments and notify myself and identified person(s) documented above. If your request is denied, Mission Health will notify me denial may be for the following reasons: (1) Documentation not created by Mission Health, (2) Documentation is not part of the designated record set, (3) Documentation is accurate and complete.

I have the right to disagree with denial and submit a written statement of disagreement. This must be done within (30) days of being notified of the denial. My written statement of disagreement will be included in future disclosures of my protected health information associated with this amendment request.

Signature of Patient or Legal Representative: _____ Date: _____ Time: _____

For Mission Health, Inc., USE ONLY - Response due within 60 days of request.

The above request for amendment has been: Accepted Denied

If denied, check the reason for denial:

- Documentation specified is not created by Mission Health
- Documentation specified is not part of the patient's designated record set
- Documentation specified is accurate and complete

Comments: _____

Signature: _____ Date: _____ Time: _____

Print Name: _____

Health Information Management, USE ONLY

Notified patient of acceptance or denial on: _____

DO NOT WRITE IN MARGIN

DO NOT WRITE IN MARGIN

DO NOT WRITE IN MARGIN

MHS-04600-106-0218



C0000-130



Mission Health System
HIPAA Request for
Amendment
of Protected
Health Information

