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 of 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

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Mission Health System

HIPAA Request for Amendment of Protected Health Information