Dartmouth Health

Request for Amendment of Protected Health Information (PHI)

MRN:

NAME:

DOB:

two identifiers needed or patient label

Address: _____

Phone: _____

What is your reason for making this request: _____

_____

_____

Describe the document(s) you want amended. Please include all relevant dates. _____

_____

_____

_____

How do you believe the document should read? _____

_____

_____

_____

Do you know of anyone who may have received or relied upon the information in question (such as your doctor, pharmacist or insurance company)? ☐ Yes ☐ No

If yes, please specify the name(s) and address(es) of the organization(s) or individual(s):

_____

_____

_____

Signature of Patient or Personal Representative Date

_____

Printed Name of Patient or Personal Representative Legal Authority of Personal Representative

Received by HIS

***Please return completed form to:**

Dartmouth Health
Attn: HIS Chart Correction
One Medical Center Drive
Lebanon, NH 03756

At your request, we will provide you with a copy of this form.

Dartmouth Health

Request for Amendment of Protected Health Information (PHI)

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FOR INTERNAL USE ONLY

Health Information Services (HIS):

HIS Received request on:_____

Response due back to HIS by:_____

- ☐ eDH EMR (electronic medical record) to be reviewed
- ☐ Legacy Record to be reviewed *(includes paper chart and/or legacy EMR)*
  - ☐ Dartmouth Hitchcock
  - ☐ Cheshire Medical Center *(prior to November 2017)*
  - ☐ Alice Peck Day Memorial Hospital *(prior to May 2019)*
  - ☐ New London Hospital *(prior to October 2020)*
  - ☐ Visiting Nurses of Vermont and New Hampshire *(prior to May 2022)*
  - ☐ Hanover Psychiatry *(prior to May 2022)*

To be Completed by Originator of Document:

- ☐ Request for Amendment is accepted. I have amended the documentation in the medical record as requested.
- ☐ Request for Amendment is accepted in part and denied in part.

I have agreed to amend the following: _____

_____

I have denied the request to amend the following (complete next section also): _____

_____

- ☐ Request for Amendment is denied in whole or in part. Check the reason for denial:
  - ☐ Health information was not created by Dartmouth Health.
  - ☐ Information not part of the health information the patient is permitted to inspect, pursuant to Federal law, 45 CFR § 164.524.
  - ☐ Information is not part of a designated record set maintained by or for Dartmouth Health.
  - ☐ Information is accurate and complete.

_____

Signature of Originator of Document Date

_____

Printed Name of Originator of Document