Dartmouth Health

Request for Amendment of Protected Health Information (PHI)

MRN (optional): _____

Patient Name: _____

Date of Birth: _____

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.