Request Form for Protected Health Information (PHI)

Client Information:
Name: _____
Date of Birth: _____

I request that the following information in my health record be amended:
(Please specify the information and describe the nature of the amendment.)

Reason for Amendment:
(Explain why you believe the information is incorrect or incomplete.)
_____
_____
_____

Acknowledgment:
Please be aware that your request may be denied if the information is found to be accurate, or if the amendment is not required by law. You will be notified in writing if your request is denied.

Signature of Client or Legal Representative:
Signature: _____
Date: _____

Legal Representative Information (if applicable):
Name: _____
Relationship to Client: _____

**Fees may apply for processing amendment requests, in accordance with state law.*
Your amendment request will be processed within 60 days. If an extension is needed, you will be notified in writing.

Covered Entity Representative:
Name: _____
Signature: _____
Date: _____