UnityPoint Health

REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION

Patient Name: _____
Last **First** **MI**

Home Address: _____

_____

Phone: _____ **Date of Birth:** _____

I hereby request that UnityPoint Health amend **(please check all boxes that apply):**

____ My medical records
____ My billing records
____ My enrollment, payment, claims adjudication, case or medical management records
____ My records used by or for UnityPoint Health to make decisions about me,

all more specifically described below.

I understand that UnityPoint Health may deny this request as permitted under federal law. I further understand that if UnityPoint Health denies my request, I will be informed in writing by UnityPoint Health its reason for the denial and what I should do if I disagree with the denial. I further understand that UnityPoint Health will notify me of its decision to accept or deny my request within sixty (60) calendar days of receiving this request. If UnityPoint Health is unable to comply with my request within this time frame, I understand that it may extend the applicable deadline for up to an additional thirty (30) calendar days by notifying me in writing.

1. Describe the information you want amended (e.g. procedures, nursing/physician notes, test results)

_____

_____

_____

_____

2. Date(s) of information to be amended (e.g. date of office visit, treatment, or other health care services)

_____

_____

UnityPoint Health

3. **What is your reason for making this request?:** _____

_____

_____

4. **How is the entry incorrect, incomplete, or outdated?** _____

_____

_____

5. **What should the entry say to be more accurate or complete? (Please be as specific as possible)**

_____

_____

_____

6. **Do you know of anyone who may have received or relied on the information in question (such as your doctor, pharmacist, health plan, or other health care provider? Yes_____ No _____**

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

_____

_____

_____

Signature of Patient or Patient's Personal Representative **Date**

FOR UNITYPOINT HEALTH USE ONLY: **Patient MRN:_____**

Amendment has been _____ Accepted _____Denied

If denied, check the reason for denial:

___ Protected Health Information was not created by UnityPoint Health
___ Protected Health Information is not part of the patient's Designated Record Set
___ Protected Health Information is not accessible by the patient under UPH policy regarding the patient's right to access their Protected Health Information
___ Protected Health Information is accurate and complete

Comments: _____

_____

Signature of Privacy Officer: _____ **Date:** _____