The Christ Hospital™ Health Network

2139 Auburn Ave.
Cincinnati, OH 45219

513.585.2000

# AMENDMENT OF PATIENT PROTECTED HEALTH INFORMATION (PHI) REQUEST FORM

You have the right to request The Christ Hospital Health Network to make amendments to the protected health information (PHI) that The Christ Hospital Health Network retains on your behalf if you believe something in that information is in error or needs to be amended. We are not always required to make the amendments you request but each request will be carefully reviewed and amendments made if warranted. You will be notified when your request has been approved or denied.

Last Name_____ First_____ Middle_____

Address_____ City_____ State_____

Zipcode_____ Phone_____ SS#_____

DOB_____ MRN_____ Encounter #_____

Please provide as much detail as possible regarding the amendment you seek in your medical record. Be as specific as possible regarding the record type, the location, the date and the problem. For instance, “my laboratory test results from April 15, 2010, show a blood test that was not performed.”

_____
_____
_____
_____

Please state as precisely as possible the amendment you wish made to the record.

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_____
_____
_____

If you are aware of any other person(s)/entity (for example a physician(s) or another hospital) that may have a copy of the medical record you seek to have amended, please list the name(s) and address(es) here.

_____
_____
_____

I HEREBY AUTHORIZE The Christ Hospital Health Network to notify the persons/entities I have listed above that may have a copy of the record I seek to have amended and to provide them with the amended information.

_____ _____
Signature of Patient/Legal Representative* Date

*Describe scope of authority to act for patient_____