Khan Medical Associates, LLC

Patient name			
MHN	DOB	Age	Gender

Amendment/Correction of Health Information Request

Street address		Request date (month/day/year) / /
City	State	ZIP code

WHAT NEEDS TO BE AMENDED/CORRECTED AND WHY

Entry to be amended ____

Date of entry (month/day/year) ______ /______ /______ Author of entry ________________________

Explain how your health information is incorrect or incomplete. What should your health information state to be more accurate or complete.

____

____

____

~~Would you like this information sent to anyone to whom we may have disclosed this information in the past:~~

Yes _____ No _____

If yes, specify the name and address of the organization or individual:

Name ____

Address

I understand that Khan Medical may or may not amend my medical record with an amendment based on my request. This request for an amendment will be made part of my permanent medical record.

/___/____ ___________

Patient signature (Patient's legal representative) (Relationship) Signature date (m/d/y) Phone number

Forward completed request to Release of Medical Information, Khan Medical Associates, LLC 200 Penn Ave, Pittsburgh, PA 15221

FOR KHAN MEDICAL INTERNAL USE ONLY

Date received

___ Accepted ___ Denied

If denied, check reason for denial:

____ PHI was not created by Khan Medical ___ Other (specify) ___

____PHI is not part of patient's designated record set __ PHI is accurate and complete

Comments: ____

_____ Individual was informed of denial in writing (attach letter of communication)

____________________________________ / /

Signature/Title of staff member Date (month/day/year)

 © 2003 Marshfield Clinic