

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
<p>____ Accepted ____ Denied</p> <p>If denied, check reason for denial:</p> <p>____ PHI was not created by Khan Medical ____ Other (specify) ____</p> <p>____ PHI is not part of patient's designated record set ____ PHI is accurate and complete</p> <p>Comments: _____</p> <p>____ Individual was informed of denial in writing (attach letter of communication)</p>	
Signature/Title of staff member	Date (month/day/year) ____/____/____