Health Information Amendment Form

*To request an amendment to your health information, complete this form in its entirety, and submit it to the CHS Facility or Practice where you were treated. To get the address of the appropriate Facility or Practice, please go to www.carolinashealthcare.org and select "Location". You will receive a response to your request within 60 days of when we receive your written request.

Patient Name:_____Date of Birth:_____SS#Last 4 Digits:_____

Address:_____

City:_____State: _____Zip Code:_____

Home Phone: (____)_____Work Phone: (____)_____Cell Phone: (____)_____

Name the CHS Facility/Practice and address you want to amend your record:_____ _____

_____ _____

Include the name(s) of the Person/Caregiver/Provider of the information you want amended:_____ _____

_____ _____ _____

Include the treatment dates of the information and documents you want amended:_____ _____

_____

Describe why you think the information is inaccurate:_____

_____

State your requested amendment(s):_____ _____

_____

Would you like this amendment to be provided to anyone to whom we may have disclosed the information in the past? If so, please specify the name and address of the organization or individual:_____

_____

Signature of Patient or Representative:_____Date:_____

If signing as authorized representative, describe your authority to act for the patient, and submit documentation showing such authority, as appropriate:_____

_____ _____ **For Carolinas HealthCare System Use Only** _____

Amendment has been: ____Accepted ____Denied ____Partial Acceptance/Denial

If denied (fully or partially), check reason:

___ PHI was not created by Carolinas HealthCare System

___PHI is accurate and complete

___ PHI is not part of the patient's designated record set

___ PHI is not available for amendment as permitted by Federal Law

Signature(s):_____ Date:_____

Print Name & Title:_____

Comments:_____

_____

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Carolinas HealthCare System

Original: File or Scan in medical record