REQUEST TO AMEND PROTECTED HEALTH INFORMATION

You have the right to request an amendment to your Protected Health Information by completing this form and sending it to:

Health Information Management Department
Reading Hospital
PO Box 16052
Reading, PA 19612-6052

PLEASE PRINT

Your Name: ______________________________ Date of Birth: ______________________
month day year

Home Address: ______________________________

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Please explain how the entry in your medical record is incorrect or incomplete.

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I understand that by listing the names and addresses of other organizations on this Amendment form, I am asking Reading Hospital to take reasonable steps to disclose the requested amendment to these organizations. I therefore give specific permission to Reading Hospital to disclose the amendment to these organizations.

PLEASE SPECIFY THOSE ORGANIZATIONS ON PAGE 2 OF THIS FORM

In addition, I understand that Reading Hospital may be required to send this amendment to its business associates and other organizations that need to know about this amendment. I give specific permission to send the requested amendment to those organizations identified by Reading Hospital as needing the amendment.

White Copy: Director, Health Information Management Yellow: Patient Copy

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THESE ARE THE ORGANIZATIONS THAT I WANT TO BE INFORMED OF THE REQUESTED AMENDMENT:

Name/Address: ______________________

Name/Address: ______________________

Name/Address: ______________________

Name/Address: ______________________

Note: If you have additional names, please attach an additional sheet to this page.

My signature below signifies that I fully acknowledge and agree to the above terms.

______________________ PRINT PATIENT NAME

______________________ DATE OF BIRTH

X______________________ PATIENT SIGNATURE OR AUTHORIZED REPRESENTATIVE

______________________ DATE

White Copy: Director, Health Information Management Yellow: Patient Copy