PATIENT REQUEST: **CORRECTION / AMENDMENT OF PROTECTED HEALTH INFORMATION**

*Purpose: To request amendment or correction of PHI maintained in patient health records**

Please check the appropriate box and fill in the blank as needed:

❒ _____ (name of facility)

❒ All WellStar entities

Please complete the following section (print clearly):

Patient's Last Name	First Name	MI	Birth Date (Month / Day / Year)

Street Address / Apt # (include complete mailing address)	Medical Record Number (if known)

City	State	Zip	Home Phone #	Alternate Phone #

REQUEST DETAILS: I hereby request amendment / correction of my Protected Health Information as indicated below (check all that apply):

❒ Medical Records ❒ Billing Records ❒ Other: _____

Type of information to be amended (please list specific reports, results, etc.): _____

Date(s) of information to be amended (i.e. date of visit, treatment, or service): _____

Please explain how the information is incorrect or inaccurate (please attach any supporting documentation to this form):

What should the entry state in order to be more accurate or complete? _____

PATIENT AGREEMENT (please check (X) the appropriate response):

Would you like this amendment sent to anyone to whom we may have disclosed information in the past? ❒ Yes ❒ No

If yes, please specify the name and address of the organization(s) or individual(s):

PATIENT SIGNATURE:

_____ Date of Request

_____ (or) _____

Print Name — Print Name of Legal Guardian/Authorized Personal Representative

_____ (or) _____

Signature of Patient — Signature of Legal Guardian / Authorized Personal Representative*

*Wellstar will respond to your request within 60 days.

*Please indicate your relationship to the patient:

❒ Parent or Guardian of an Unemancipated Minor
❒ Guardian or Conservator or an Incompetent Patient
❒ Medical Durable Power of Attorney
❒ Other: _____

Wellstar Health System / Attn: Chief Privacy Officer
793 Sawyer Road, Marietta, GA 30062
(O) 470-644-0444 / (F) 770-509-4236 email: privacyofficer@wellstar.org

Wellstar Health System

Patient Request: **Correction / Amendment of PHI**