HOAG MEMORIAL HOSPITAL PRESBYTERIAN

REQUEST TO AMEND PROTECTED HEALTH INFORMATION

Patient Name: _____

Date of Birth: _____

Date(s) of Service: _____

Specify document(s): _____

Please tell us what health information you want changed: (Please be specific)

_____

_____

_____

_____

Please tell us why you want this change. You must give a reason:

_____

_____

_____

We must tell you within 60 days if we will change your protected health information (as you have requested), or tell you if we need more time (up to 30 extra days) to decide.

Please enter where we should send the letter and a phone number:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

If we decide to change the health information you requested, we will send the change to any person who received the information before it was changed. Are there individuals who require the changed version? ☐ No Initials: _____ ☐ Yes Initials: _____

If yes, please list the names and addresses:

_____ _____

_____ _____

_____ _____

We will also send the amendment to other persons who we know received the information before it was amended, if they relied on, or might in the future rely on, the information to your detriment (harm). Do you agree to this? ☐ No Initials: _____ ☐ Yes Initials: _____

We **do not** have to change your protected health information if:

1. We did not create the information, unless the person who created the information is unavailable to act on your request to change it (for example, the doctor who originally created the information has died). If this exception applies to you, please explain:

   _____

   _____

   _____

   _____

2. The information is accurate and complete.
3. You do not have the legal right to access the protected health information you want changed or amended.
4. The protected health information you want changed is not part of the designated record set. This includes your medical records, billing records and records containing your protected health information that are used by us to make decisions about you.

For more information about your privacy rights, see the "Notice of Privacy Practices" available on our website at www.hoag.org or at the Health Information Management Department or by sending a written request to: Hoag Hospital, Patient Relations Department, One Hoag Drive, Newport Beach, California, 92658-6100.

If you believe your privacy rights have been violated, you may file a complaint with the hospital or with the Secretary of the Department of Health and Human Services. To file a complaint with the hospital, contact Patient Relations at the address above or call (949)764-8220. All complaints must be submitted in writing. *You will not be penalized for filing a complaint.*

_____ _____ _____ A.M./P.M.
[Signature of Patient or Legal Representative] [Date] [Time]

If signed by other than patient, indicate relationship: _____

Print Name (legal representative): _____

When you have finished filling out this form, please send it or bring it to:

Hoag Hospital
Health Information
One Hoag Drive, Newport Beach, CA 92658-6100
Attention: Director HIM