South Shore Health

South Shore Hospital
55 Fogg Road, Box 55
S. Weymouth, Ma 02190
781-624-8843

Request for Amendment of Protected Health Information

1. Patient LAST Name:_____FIRST Name:_____Birth Date:_____
2. Medical Record Number:_____Date of Service: _____
3. Street Address, City, State, ZIP: _____
4. Best Contact Number:_____ Can we leave a message at this number? Yes or No
5. Describe the type of document to be amended (e.g., Progress Note, History & Physical, Discharge Summary, etc.):_____
6. Date of document to be amended:_____Author of document to be amended :_____
7. Explain why you believe the entry is incorrect and/or incomplete (use additional pages if necessary):

_____

_____

8. What do you believe the information should state to be more accurate or complete? _____

_____

9. X_____ _____
   Signature of Patient or Legal Representative — Date
10. _____
    Relationship to Patient if Signed by Legal Representative

FOR HOSPITAL USE ONLY

Date Received: _____

Request for amendment is: ☐ Fully Approved ☐ Partially Approved ☐ Denied

If denied, check reason for denial:

1. The information was not created by this hospital
2. The information is not part of individual's legal medical record
3. The author of information is no longer associated with the hospital
4. The information is accurate and complete
5. Per federal or state law, the information is not available for inspection by the patient (e.g., psychotherapy notes)

Additional comments: _____

_____ _____
Signature of author of entry that is the subject of the request — Date

See reverse for instructions for filling out this from.

INSTRUCTIONS FOR AMENDMENT REQUEST

Please fill out the "Request for Amendment of Protected Health Information" form completely and accurately, following the directions below for numbers 1 – 9 of the form.

1. Please document patient's LAST name, Patient's FIRST name and patient's date of birth.

2. Please provide medical record number and date of service for the visit in question.

3. Please provide full mailing address.

4. Please provide home, cell and/or work number.

5. Indicate the title of the document that needs to be amended (ie. Emergency Department Dictation, Discharge Summary, Progress Note).

6. Please provide the date of the document as well as the author name/provider name that wrote the document.

7. Explain why you believe the document is incorrect and/or incomplete (use additional pages if necessary).

8. Please document what you believe the information should state to be more accurate or complete.

9. **Signature** of patient/legal representative/guardian and **date** must be provided.

10. Indicate your relationship to patient if not signed by patient.

If you have any questions regarding this form or your medical records, please contact Health Information Management/Medical Records at 781-624-8843.