Washington University Physicians®

in Illinois INC.

Request for Amendment of Protected Health Information

Request Date: _____

Individual Name: _____ DOB: _____

Patient Address: _____

Telephone Number: (Home) _____ (Work) _____

After review of my medical record, I am requesting that information on the following service date(s) _____ be amended/supplemented with clarifying information and added in the form of an addendum to my medical record. I am requesting this amendment because:

_____

I understand that Washington University Physicians in Illinois, Inc. may or may not amend/supplement my medical record based on my request. Under no circumstances, may Washington University Physicians in Illinois, Inc. alter the original documentation of my medical record.

Amendment Request:

I request the following amendment/supplement be made to my medical record:

_____

_____

_____

_____

_____

_____

I hereby agree and acknowledge that Washington University Physicians in Illinois, Inc. will notify those persons I have designated below as well as others with whom Washington University Physicians in Illinois, Inc. has previously shared my health information of this amendment of my health information.

Signature (Individual or Legal Representative) Date

_____

Do you know of anyone who may have received or relied on the information in question (such as your doctor, pharmacist, health plan, or other health care provider)?
___ Yes ___ No

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

_____

_____ _

For Washington University Physicians in Illinois, Inc. Use Only:

Amendment has been: ___ Accepted ___ Denied

____ In response to your request, an amendment/supplement will be made part of your permanent medical record.

____ Your request has been denied for the following reasons:

___ Information was not created by this organization.

___ Information is not part of the Designated Record Set.

___ Federal law prohibits making the Information available to the patient for inspection (e.g. psychotherapy notes).

___ Information is accurate and complete.

___ Other: _____

Staff comments: _____

_____

Signature of Staff Person _____ Date _____

Print Name & Title _____

Statement of Disagreement:

If you do not agree with the above information, you may submit a Statement of Disagreement that will become part of your permanent record and included in any future disclosure of the subject medical information. Please outline the reason for your disagreement in the space provided below: (may attach no more than 2 pages)

_____

_____

_____

_____

_____

_____

I do not wish to submit a Statement of Disagreement. However, I am requesting that Washington University Physicians in Illinois, Inc. include in any future disclosure my request for amendment form and Washington University's Physicians in Illinois, Inc.'s denial.

_____ _____

Individual or Legal Representative Signature Date

Mail this form to: Washington University
HIPAA Privacy Office
660 South Euclid Ave., Campus Box 8098
St. Louis, MO 63110