# 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 of receipt of request 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:

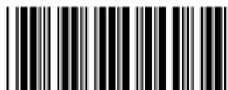
______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

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: _____







**Medical Record Number:**

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 by sending a written request to: Hoag, Attn: Hoag Corporate Compliance, One Hoag Drive, PO Box 6100, Newport Beach, CA, 92658-6100.

If you believe your privacy rights have been violated, you may file a complaint with Hoag Corporate Compliance or with the Secretary of the Department of Health and Human Services. To file a privacy rights complaint with Hoag Corporate Compliance, please call (949) 764-4427 or e-mail CorporateCompliance@hoag.org. *You will not be penalized for filing a complaint.*

Patient/Legal Representative Signature: ____________________ Date: _______ Time: _____ A.M./P.M.

If signed by other than patient, indicate relationship: ______________________________

Print Name (Legal Representative): ______________________________________

When you have finished filling out this form, please mail or e-mail to:

**Hoag Memorial Hospital Presbyterian**
**Attn: Medical Records/Health Information**
**One Hoag Drive, PO Box 6100, Newport Beach, CA 92658-6100**

**E-mail: hoagmedicalrecords@hoag.org**

Or in person to:

**Hoag Memorial Hospital Presbyterian Medical Records (Newport Beach - East Tower)**
**One Hoag Drive, Newport Beach, CA 92663**

**or**

**Hoag Memorial Hospital Presbyterian Medical Records (Irvine)**
**16200 Sand Canyon Ave., Irvine, CA 92618**

**or**

**Any Hoag Clinic (Urgent Care or Hoag Medical Group)**



Original – Chart Photocopy for Patient

**Medical Record Number:**

## INSTRUCTIONS

Incomplete forms cannot be processed by Hoag's Health Information department. Please make sure the form is completed in its entirety.

Requests to amend health information can take up to 60 days. We must tell you within 60 days of receipt of your request if we will change your protected health information or tell you if we need more time (up to 30 extra days) to decide.

1. Provide your legal name, date of birth, the date or dates of service your request pertains to and specify which documents in your medical record this applies to (e.g., 1/01/2022 Progress Note by Dr. Smith, 1/10/2022 Nursing Note by Sally Jane, RN)

2. Please tell us specifically what health information you would like changed.

3. Please tell us why you want this changed. You are required to provide a reason for your request.

4. Please provide us the name, full address and phone number of where you would like the Hoag Health Information team to send our response to your request when completed.

5. Please notify us if there are any individuals who require a copy of any approved changes to your medical record. You must provide their name(s) and complete address(es) otherwise information will not be sent.

6. Please determine if you would like Hoag's Health Information department to send the amended record 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).

7. Hoag does not need to change your protected health information if 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, you must provide an explanation.