



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  
Health Information Management Department  
660 South Euclid Ave., Campus Box 1219  
St. Louis, MO 63110  
  
(314) 273-0570