POMONA VALLEY HOSPITAL
MEDICAL CENTER
Expert care with a personal touch

Request for Correction/ Amendment of Health Information

Patient's Name _____ Date of Birth _____

Phone Number _____ Social Security Number _____

Address _____ City _____ State _____ Zip Code _____

MRN: _____ Date of Service (s) to be amended _____

Name of Document(s) to be amended _____

_____

_____

_____

_____

Please explain how the entry is incorrect or incomplete.

_____

_____

_____

_____

Would you like this amendment sent to anyone to whom we may have disclosed the information? If so, please specify the name and address of the organization or individual.

_____ _____
Name Address

_____ _____
Name Address

_____ _____
Name Address

We will respond within 60 days of receipt, if we will amend your health information as you requested, or notify you that we need more time (up to 30 extra days) to make a decision.

_____ _____
Signature of Patient or Legal Representative Date

_____
Relationship to Patient

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For Healthcare Organization Use Only:

Date Received _____ Amendment has been: [ ] Accepted [ ] Denied

[ ] Denial Letter sent

Reason for denial:

[ ] PHI was not created by this organization

[ ] PHI is not part of patient's designated record set

[ ] PHI is not available to the patient for inspection as required by federal law

[ ] PHI is accurate and complete

Patient MRN: _____

Comments of Healthcare Practitioner:

_____

_____

_____

_____

_____ _____

Healthcare Practitioner Name (Print) Date

_____

Healthcare Practitioner Name (Signature)

_____ _____

Health Information Management (Print) Date

_____

Health Information Management (Signature)