Northwell Health℠
North Shore-LIJ Health System is now **Northwell Health**

REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION

I hereby request that my Protected Health Information be amended as described below:

PATIENT NAME (PRINT): _____ **DATE OF BIRTH:** _____

Street Address: _____

Suite/Apt. Number (if applicable): _____ City: _____

State: _____ Zip Code_____ Phone Number: _____

Facility in which Protected Health Information was created:

_____

_____

Description of requested amendment (attach additional pages, if necessary):

_____

_____

_____

Description of reason for requested amendment:

_____

_____

Description of entities to which the Health System should provide information about this requested amendment if accepted:

_____

_____

Description of entities to which the Health System should provide information about this requested amendment if it is denied:

_____

_____

This form must be submitted to the respective facility's Health Information Management Department and/or Practice Manager.

_____ _____
Patient/Agent/Relative/Guardian* (Signature) Date / Time

_____ _____
Print Name Relationship if other than patient

_____ _____
Telephonic Interpreter's ID # Date / Time
OR

_____ _____
Interpreter (Signature) Date / Time

_____ _____
Print Interpreter's Name Relationship to Patient

_____ _____
Witness to signature (Signature) Date / Time

_____
Print Witness Name

* The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or is otherwise incapable of signing.

FACILITY USE ONLY:

Received by: _____ Date: _____

☐ Accepted/Date Notice Mailed _____ ☐ Denied/Date Notice Mailed _____

Copy 1 – Patient Medical Record **Copy 2** – Health Information Management **Copy 3** – Patient or Patient's Personal Representative