Main Line Health®

REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION

Patient's Name: _____ _____ _____
Last First Middle

Home Address: _____

_____

Home Phone: _____ **Date of Birth:** _____

Dates of Service: _____

Medical Record Number: _____

Check MLH location where you were treated:

☐ Bryn Mawr Hospital ☐ Lankenau Medical Center ☐ Paoli Hospital ☐ Bryn Mawr Rehab ☐ Riddle Hospital

☐ Mirmont Treatment Center ☐ Main Line HealthCare practice: _____

☐ Other: _____

I hereby request that Main Line Health amend **[please check all boxes that apply]**:

☐ My medical records.

☐ My billing records.

☐ Any other records used to make decisions about me.

I understand that Main Line Health may deny this request as permitted under Federal law, and that I will be informed by Main Line Health concerning the basis for the denial along with instructions concerning my right to submit a statement disagreeing with such denial. I further understand that Main Line Health will notify me of its decision to accept or deny my request within sixty (60) days of receiving this request. If Main Line Health is unable to comply with my request within this time frame, I understand that it may extend the applicable deadline for up to an additional thirty (30) days by notifying me in writing.

I also understand that Main Line Health will contact my health care provider(s) involved in my care, if the amended information concerns my clinical treatment, while a patient at MLH.

Note: If this Amendment Request is approved, the mechanism for "correction" may not delete the original entry in your medical record, rather a new note will be added by the provider clarifying the incorrect information.

1. Describe the information you want amended or added (e.g., procedures, provider notes / documentation, test results, medical/family/social history, diagnosis)

2. Date(s) of information to be amended (e.g., date of test, visit, treatment, or other health care services)

3. What is your reason for making this request?

4. How is the entry incorrect?

5. What should the entry say to be more accurate? (Please be as specific as possible)

6. 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 individuals(s).

Printed name of Patient (or Personal Representative): _____

Relationship to Patient: _____

Please print and sign with blue or black ink.

Signature of Patient (or Personal Representative) _____ Date _____

Please submit the completed form via fax or mail:

Fax # 610-356-3531

Address to mail:

Health Information Management, Main Line Health, 3803 West Chester Pike, Suite 160, Newtown Square, PA 19073