HENRY FORD HEALTH℠

Request for Amendment to Patient Information

Place patient label here or fill out information below:

Patient Name: _____

Date of Birth: _____

MRN: _____

You have the right to ask for corrections or amendments to Personal Health Information (PHI) if you think there is a mistake or something needs to be changed. We review each request carefully, and corrections are made if needed. We do not always make the corrections you request.

We must respond to your request within sixty (60) days once we get it. We will let you know if part or all of your request is approved or denied.

You may return this form in one of the following ways:

Mail:
Henry Ford Health System - Health Information Management Department
1414 E Maple Road
Troy, MI 48083

Email:
himpatamendreqefax@hfhs.org
If you choose to email this form, the email may not be encrypted and your information could be viewed while in electronic transit.

Fax:
248-607-6946

Requestor Information

If the person requesting the correction is the personal or legal representative of a patient, please attach a certified document of your status as the personal or legal representative, such as Durable Medical Power of Attorney or Guardianship papers.

☐ Check here if proof of personal or legal representation is already documented in the patient's medical record.

Patient Name:_____

Last 4 Digits of Social Security Number _____ Date of Birth _____

Requested by (if not thepatient):

Relationship to Patient: _____

Patient/Requestor Address: _____

Telephone Number _____

Requestor Signature: _____ Date: _____

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Amendment Information

Check the records you want to correct/amend:

- ☐ Test Results
- ☐ Office Note
- ☐ Treatment Information
- ☐ Emergency Visit
- ☐ Diagnosis
- ☐ Other

Write down dates of service and reason for corrections below.

☐ Check here if you have attached extra information to this form.

_____

_____

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☐ Check here if you want Henry Ford Health System (HFHS) to contact third parties about this correction. Please add the information below:

Individual or Organization Name	Address	Phone Number

For HFHS Use Only

Date Received: _____ Date Completed: _____ Processed By: _____

Extension Need: ☐ Yes ☐ No

☐ Approved ☐ Partial Approval ☐ Denied Date Response Letter Sent to Patient: _____

Additional Comments: _____