St. Luke’s Hospital - AMENDMENT REQUEST FORM

St. Luke’s Hospital allows you the right to request an amendment to the medical and health information we retain on your behalf, if you believe something in that information is in error or needs to be amended.

We are not always required to make the amendment you request, but each request will be carefully reviewed. You will be notified in writing within 60 days if your request has been approved or denied.

Patient Name: ____

Birthdate: ____

Patient Address:

____

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Daytime Phone Number: ____

Name of St. Luke’s Entity Treatment Occurred: _____________________________________

____

Date(s) of Entry:

____

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Title of Document where error occurred:

____

☐ Check if the error was viewed in your MyChart patient portal

Please explain specifically how the documentation is incorrect or incomplete.

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Please explain specifically what the documentation should say to be more accurate or complete? Please attach additional sheets or attach copies of the incorrect documentation, when possible.

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I hereby authorize St. Luke's Hospital HIS Department Manager to notify the persons/entities I have listed below that may have a copy of the record I seek to have corrected and to provide them with the amended information. You must include specific names and addresses.

Name ____

Address ____

Name ____

Address ____

Name ____

Address ____

Signature of Patient or Legally Authorized Representative

____ Date ______________

You MUST attach proof of your authority to act on behalf of the patient if signed by the patient's legal representative

I understand that my request will be considered, but may not be granted if St. Luke's Hospital HIS Department Manager determines that my protected health information or record that is subject to this request:

- Was not created by St. Luke's Provider or Covered Entity, unless I provide a reasonable basis to believe that the originator of protected health information is no longer available to act on the requested amendment;
- Is not part of my medical or billing record;
- Would not be available for me for inspection under applicable law dealing with access to protected health information; or
- Is accurate and complete.

RETURN COMPLETED FORM TO:

St. Luke's Hospital

c/o HIS Department Manager

5901 Monclova Road

Maumee, Ohio 43567

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Medical Record Number: ____________________________

Account Number: __________________________________

Date Received: ____________________________________

Amendment has been:

☐ Accepted

☐ Denied

If denied, check reason for denial:

☐ Protected Health Information (PHI) was not created by this organization

☐ PHI is not available to the patient for inspections required by federal law (e.g., psychotherapy notes)

☐ PHI is not part of the patient's designated record set

☐ PHI is accurate and complete

Comments of Reviewer:

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Name of Staff Member Title

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Signature of Health Care Provider Date

Status

Extension requested on ______________________. Reason extension needed was

____.

Request approved. Notice sent on ____

Request denied. Notice sent on ____