CENTRAL OHIO PRIMARY CARE

REQUEST TO AMEND PROTECTED HEALTH INFORMATION (PHI)

Please Print

Patient's Name: _____ **Date of Birth:** _____
Last **First** **Middle** **(M/D/Y)**

Address: _____
Street **City** **State** **Zip**

Telephone Number Where You Can Be Reached: _____

Is the address above where you would like your response mailed: □ Yes □ No

If no, please provide an alternate mailing address: _____

Date of Request:_____ **Physician:** _____ **Practice:**_____

1. **Please describe the health information you want to change (e.g. physician/nursing notes, lab results, etc.) and the reason you are making this request.** _____
   _____

2. **Please give the date(s) of information to be changed (e.g. date of office visit**). _____

3. **What should the information say to be more accurate or complete? (Please be as specific as possible and attach documentation if necessary).**
   _____
   _____

COPC may accept or deny your request to amend as permitted by law. We cannot amend documentation that was not created by COPC. If your request is denied, you will be informed in writing of the reason for the denial and what you should do if you disagree with the denial. You will be notified whether your request is accepted or denied within sixty (60) days of receipt of this request. COPC can extend the response period for up to an additional thirty (30) days by notifying you in writing.

If the amendment is approved, please specify any organizations or individuals that need to receive this amended information**.**

_____ _____
Name **Street** **City** **State** **Zip**

_____ _____
Name **Street** **City** **State** **Zip**

_____ _____
Signature of Patient **Date**

_____ _____ _____
Signature of Patient's Legal Representative **Relationship to Patient** **Date**

If signed by Patient's Legal Representative, please include a copy of the document authorizing your authority to act on behalf of the patient (e.g. health care power of attorney).

_____

For COPC Use Only – forward to COPC Compliance Officer

Date Request Received: _____ **Amendment Was:** □ Accepted □ Denied

If denied, check reason(s) for denial:

- □ The Request for Amendment Form was not complete. You may complete the missing information highlighted above and resubmit your request to: COPC Compliance Officer, 570 Polaris Parkway, Suite 250, Westerville, Ohio 43082
- □ The PHI was not created by COPC.
- □ The PHI or record is not available to the patient for inspection as required by federal law.
- □ The PHI is accurate and complete as determined by review.

If your request is denied: 1. You may submit a statement disagreeing with the denial; 2. Request that your Amendment Request form and denial be attached to future disclosures; and/or 3.File a complaint with the COPC Compliance Officer, 570 Polaris Parkway, Suite 250, Westerville, Ohio 43082 or with the Secretary of the U.S. Department of Health and Human Services in Washington, D.C.

Patient Notified By: □ Regular Mail □ Courier □ Certified Mail **Date Sent:** _____

_____ _____ _____ _____
Signature of COPC Authorized Representative (Name/Title) **Date** **Signature of Health Care Provider (if applicable)** **Date**

Form Revision: 9/23/2013