Sparrow

1215 East Michigan Avenue
P.O. Box 30480
Lansing, Michigan 48909-7980

Request for Amendment of Protected Health Information

Patient's Name:_____ Birth date:_____

Address:_____ Phone No.:_____

City/St/Zip:_____

Under the Health Insurance Portability and Accountability Act (HIPAA), you have a right to request that health information that pertains to you be amended if you believe that it is incorrect or incomplete. Sparrow Hospital (or _____ _____) will review your request and either grant your request or explain the reason why it will not be granted. In the event that your request is not granted, you have the right to submit a statement of disagreement that will accompany the information in question for all future disclosures.

I, _____ (print name) believe that the following health information pertaining to the above named patient is incorrect or incomplete (please restate the challenged entry below or attach a copy of the challenged entry and identify its location in the medical record):

_____

_____

_____

I believe that the information described above is incomplete or incorrect for the following reasons:

_____

_____

_____

I hereby request that you amend the health information identified above as follows:

_____

_____

_____

Additionally, I request that the following people or entities be notified of the correction:

Name Mailing Address

_____

_____

_____

We will not make the requested changes if:

1. They do not involve your medical records, billing records or other records that we use to make decisions about you; or
2. They involve records that you do not have the right to access; or
3. We did not create the information (unless the person or entity that created the information is unable to act on your request); or
4. The information is already accurate and complete; or
5. The results of the amendment would cancel or alter a prior protected health information entry.

If Sparrow Hospital (or _____) agrees to amend your information, we will communicate the changed information to the persons or entities that you have designated above. We will also make reasonable efforts to communicate the changed information to any other persons or entities that we know have received

the information before it was amended. If the _____ is not able to act on this request in 60 days, you will be notified of the reasons for the delay.

_____ _____
Signature of patient Date

Complete only if patient or representative signs by use of a mark:

_____
Printed name of witness

_____ _____
Signature of witness Date

_____
Printed name of witness

_____ _____
Signature of witness Date

[If the above signature is that of a patient's representative, Sparrow must complete the following.]

Sparrow has verified the identification of _____ (patient's representative name) by _____ (type of verification, e.g., driver's license) and that in his/her capacity of _____(description of authority to act, e.g. legal guardian, patient authorized representative, power of attorney for medical care including medical records, executor of estate).

Verification completed by:

_____ _____
Associate name and signature Date

REVIEW SECTION: (This section is to be completed by the reviewer)

Reviewer's Decision: Granted _____ Denied _____
(Attach copy of Response to Request for Amendment of Protected Health Information)

Date received:	**Reviewed by:**
Department Director:	**Review Date:**

Reviewer's Comments:

_____

_____

_____

_____ _____
Reviewer's signature Date

If your request for amendment to protected health information has been denied, you may have the right to request a reconsideration of the denial decision. You must submit your request for reconsideration in writing to Sparrow Hospital Director of Health Information Management (or _____) at the address on the top of this form. You may obtain a *Statement of Disagreement* form by calling 517-364-6913 (or _____).

Under the Health Information Portability and Accountability Act (HIPAA), you have a right to complain about our privacy policies, procedures or actions. Sparrow Health System will not engage in any discriminatory or other retaliatory behavior against you because of your complaint. All complaints must be submitted in writing to the Chief Privacy Officer at the address on the top of this form. A complaint form can be obtained from the Chief Privacy Officer by calling 517-364-6913. You may also file a complaint with the Secretary of the Department of Health and Human Services.