



REQUEST TO CORRECT/AMEND PROTECTED HEALTH INFORMATION

Please complete and return to Grady Health System, Corporate Compliance, 80 Jesse Hill Jr. Drive, SE, PO Box 26128, Atlanta, Georgia 30303 or fax to 404-489-6700. A copy of a valid driver's license or state-issued ID must be submitted for processing.

Patient Name: _____ MRN: _____

Address: _____

City, State, Zip: _____ Date of Birth: ____/____/____

Telephone#: _____ Date(s) of Treatment: _____

Email Address: _____

I understand that the Grady Health System may or may not supplement the medical record with an addendum based on my request, and that under no circumstances is the Hospital able to alter the original documentation of my medical record. This request for a m e n d m e n t may be made part of my permanent medical record and may be sent to individuals/organizations identified b e l o w as having relied on the content of my medical record.

I hereby request that the following protected health information (PHI) about me be amended (e.g., lab results, physician notes):

The following is my reason for making this request:

I would like to request the following addition/change to the information:

I believe that the following parties may have received or relied on the information in question (eg. doctor, pharmacist, or other health care provider):

Signature of Patient or Legal Representative: _____ **Date:** ____/____/____

For Healthcare Facility Use Only Date Request Received: ____/____/____ Processed By: _____

Amendment has been: Approved Partial Approval Denied. If denied, check reason for denial:

The PHI is not part of the patient's "designated record set". The PHI was not created by this organization.

The PHI is not available to for inspection as required by law. The PHI is accurate and complete.

Signature of Health Care Practitioner/Compliance Office: _____ Date: ____/____/____

Tracking # _____