Hackensack Meridian *Health*

INTERNAL USE ONLY
Date Received:
____/____/___/

REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION FORM

Patient Name: _____

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

Contact Number: _____ **Date of Birth:** _____

I hereby request that Hackensack Meridian Health and/or one of its affiliates amend [please check all boxes that apply]:

☐ Bayshore Medical Center	☐ Jersey Shore University Medical Center	☐ Riverview Medical Center	☐ Ocean Medical Center	☐ Southern Ocean Medical Center	Raritan Bay ☐ Perth Amboy ☐ Old Bridge	☐ Other: _____ _____

My medical records from _____ **(date) to** _____ **(date).**

Please explain how the information is incorrect or incomplete.

_____

_____

_____

_____

What should the information state to be more accurate or complete?

_____

_____

_____

_____

_____

_____

Request for Amendment of Protected Health Information Form (2)

Note: any requested changes regarding Date of Birth or Address, will require appropriate documentation to support.

I understand that Hackensack Meridian Health may or may not approve this request. I also understand that Hackensack Meridian Health is not able to alter the original documentation in a record under any circumstances.

I further understand Hackensack Meridian Health will notify me whether my requested is granted or denied, within sixty (60) days of receiving this request. If Hackensack Meridian Health is unable to comply with my request within this timeframe, I understand that it may extend the applicable deadline for up to an additional thirty (30) days by notifying me in writing.

_____ _____

Signature of patient or Patient's Personal Representative **Date**

_____

Printed name of the person signing and relationship to the patient

If you are NOT the patient but are signing on behalf of the patient, please comment below:

I, _____, am the (check which applies)
(print name)

- ☐ **Parent with Parental rights (*not sufficient for substance abuse records*)**
- ☐ **Registered Kinship Care Relative (*not sufficient for substance abuse records*)**
- ☐ **Court Appointed Guardian**
- ☐ **Legally appointed Healthcare Agent (*not sufficient for substance abuse records*)**
- ☐ **Medical Power of Attorney (*not sufficient for substance abuse records*)**
- ☐ **Power of Attorney (*not sufficient for substance abuse records*)**
- ☐ **Surrogate Decision Maker (*not sufficient for substance abuse records or mental health records*)**
- ☐ **Court Appointed Personal Representative of Deceased**

Representative's Signature: _____ Date: _____
(Required)

Address: _____ Phone: _____

You MUST attach proof of your authority to act on behalf of the patient as checked above (other than parent).