

**WVU PHYSICIANS OF CHARLESTON
REQUEST FOR AMENDMENT OF HEALTH INFORMATION**

SECTION A: Patient to complete the following information.

DATE: _____

PATIENT NAME: _____ BIRTH DATE: _____

PATIENT ADDRESS: _____

PATIENT TELEPHONE NO.: _____ SS NO.: _____

REQUEST:

I hereby request [WVU Physicians of Charleston \(WVUPC\)](#) to amend the following **(check all that apply)**:

My medical records My billing records

Other—please describe _____

Date(s) of information to be amended (*i.e.* date of visit, treatment, or other health care services) _____

I believe that the information is incorrect or incomplete in the following manner: _____

I request this amendment for the following reason(s): _____

The information should be amended as follows: _____

I would like this amendment sent to the following persons who may have received my health information in the past **(please specify name and address of the individuals or organizations)**: _____

I understand that [WVUPC](#) may or may not supplement the medical record with an addendum based on my request. I also understand that [WVUPC](#) is not able to alter the original documentation in the medical record under any circumstances. Regardless whether my request is granted or denied, I understand that this request will be made a part of my permanent medical record and will be sent as part of the medical record in response to any authorized requests for release of my health information.

Signature of Patient or legal representative _____

Printed name of patient or legal representative _____

Legal representative's relationship to patient _____

SECTION B: [\[PRACTICE\]](#) to complete the following.

DATE OF RECEIPT OF REQUEST _____

Request for correction / amendment has been: Accepted Denied

If denied, check reason for denial:

- The PHI was not created by this [PRACTICE].
- The PHI is not part of Patient's designated record set.
- The PHI is not available to the Patient for inspection as required by federal law (eg/ psychotherapy notes)
- The PHI is accurate and complete.

Staff comments _____

NOTICE TO PATIENT/OTHERS

Patient and/or others notified of determination via one or more of the following (**check all that apply**):

- Attachment A (Notice of Acceptance of Amendment) sent to Patient on _____
- Attachment B (Notice of Denial of Amendment) sent to Patient on _____
- Attachment C (Notice of Acceptance of Amendment) sent to identified persons pursuant to Patient authorization on _____.

Signature of staff member _____ **Date** _____

Print name and title _____