Corewell Health™

Record
REQUEST TO AMEND/ADD TO CLINICAL PROTECTED HEALTH INFORMATION (PHI)

You have requested a change/addition to your protected health information (PHI). Before we can review your request you must complete this form.

PATIENT TO COMPLETE:

PATIENT INFORMATION:

Name: Last _____ First _____ Middle _____

Date of birth (MM/DD/YY) _____ Phone contact number (_____)_____

Street address _____

City _____ State _____ Zip code _____

Email address _____

1. Name of facility/office that documented the protected health information (PHI) that you are requesting to be changed/added to _____
2. Date of service of the PHI you are requesting to change or add to _____
3. Name of person (if you know it) whose entry in the PHI you are requesting to change or add to _____
4. If your request to amend/add your clinical PHI is accepted, we will do our best to send the updated copies to persons or places that received a copy of the original record. List any other places the amendments/additions should be sent to _____
5. We are not required to change/add to the PHI if:
   a. The author states the information is accurate and complete.
   b. You do not have the legal right to the PHI you want changed.
   c. The PHI you want to amend is not a part of our medical record set. A medical record set includes medical records, billing information, and other records we use to make decisions about you.
   d. We did not create the original documentation or record.
6. Tell us the kind of information you think is not right. For example a progress note, discharge summary, or physician's office note. We also need the date you think the entry was made.
7. Tell us what you think the entry should say (use separate sheet of paper if needed)

OVER →

DO NOT MARK BELOW THIS LINE BARCODE ZONE DO NOT MARK BELOW THIS LINE

* X 1 1 9 3 2 *

PATIENT TO COMPLETE: *(CONTINUED)*

I request that you amend my PHI as above. I understand that Corewell Health may or may not add/change the information I have requested. I also understand they are not able to change the original documents in the medical record. HIM will respond within 60 days of the date they receive the request.

SEND THIS COMPLETED FORM TO THE APPROPRIATE MAILING ADDRESS OR EMAIL ADDRESS BELOW:

- **Corewell Health - West Michigan**, HIM Department
  Attention Release of Information (ROI), Mailcode 063
  100 Michigan Street, NE
  Grand Rapids MI 49503
  *Email: himamendments@corewellhealth.org
- **Corewell Health - Southeast Michigan**
  Attention: Health Information Management
  26901 Beaumont Blvd.
  Southfield, MI 48033
  *Email: cheamendreq@corewellhealth.org
- **Corewell Health - Southwest Michigan**
  Attention Medical Records
  1234 Napier Ave.
  Saint Joseph MI 49085
  *Email: himamendments@corewellhealth.org

***IMPORTANT ENCRYPTION INFORMATION:**

- If you email to us, emailing PHI is not secure if it is not encrypted. Encryption is security software that converts information/data into code. It can be used so PHI cannot be accessed easily without a password. Also, some media (e.g., compact disk (CD), USB flash drive, mobile device, etc.) is not secure.
- My medical records may contain PHI (e.g., Social Security number, home address, insurance information, medical information, personal information, etc.).
- These are risks if I do not encrypt emails that have PHI:
  - Emails could be intercepted when sending, and my PHI could be seen by others.
  - Emails could send the email to a wrong email address by accident.
  - If I or others have shared email accounts, PHI may be seen by others.
- My PHI may be seen if an email is forwarded to others, or my information is stored on a computer/server that has no encryption security.
- Corewell Health will always encrypt my PHI when they email it to me.

I have read this form or it has been explained to me. All my questions about this form have been answered.

Date _____ Patient signature _____

If a patient is under 18 years of age or otherwise unable to consent, the following must be completed:
I,_____, hereby certify that I am the _____
of the patient; that patient is unable to consent because patient is a minor, or because:

_____

Date _____ Parent, Legal Guardian,
Patient Advocate or Next of Kin signature _____

COREWELL HEALTH HIM STAFF USE ONLY:

Date request received _____

DECISION: ☐ Request approved ☐ Request denied ☐ Reason denied _____

Date above determination was mailed to patient _____ ☐ HIM scanned authorization into electronic medical record (EMR)

TIME _____ **DATE** _____ Health Information Management signature _____

