SPECTRUM HEALTH

Authorization
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. If we agree with your request we will add your comments to the record.

After you have filled in all the information, send the form to:

Name _____

Facility or office _____

Address _____

City _____ State _____ Zip code _____

COMPLETE THE FOLLOWING

1. Today's date _____
2. Patient name _____
   First Middle Last
3. Date of birth _____
4. Address _____
5. Phone contact number _____
6. Name of facility/office where your protected health information (PHI) is that you are requesting to be changed/added to _____
7. Date of service of the PHI you are requesting to change or add to _____
8. Name of person (if you know it) whose entry in the PHI you are requesting to change or add to _____
9. Tell us the kind of information you think is not right. For example, a progress note, discharge summary a physician's office note. We also need the date you think the entry was made.
   _____
   _____
   _____
10. Tell us what you think the entry should say _____
    _____
    _____
    _____
    _____
    _____
    _____

OVER →

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

X11932

COMPLETE THE FOLLOWING *(CONTINUED)*

11. If we accept your request to add to your PHI, we will do our best to send the additions to any person or place that we received a copy of the original record.

12. We are not required to change/add to the PHI if:

    a. The information in the record 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 record. If the person who wrote the information is not available to amend the record, explain below. For example, if the doctor who created the record has died.

    _____

I request that you amend my PHI as above. I understand that Spectrum Health may or may not add the information I have requested. I also understand they are not able to change the original documents in the medical record.

TIME _____ **DATE** _____

Patient or Authorized Representative signature _____

Submit completed form to Health Information Management (HIM) Department for review and approval.

Spectrum Health Medical Group send to:

- Interoffice to Health Information Management Manager at MC 063 or Fax 616.391.1521
- Patient mail request to: Spectrum Health Medical Group, HIM Manager, Mailcode 063, 100 Michigan Street NE, Grand Rapids, MI 49503
- To contact HIM Manager call 616.485.3718

Spectrum Health Hospital send to:

- Interoffice to Health Information Management Supervisor at MC 063 or Fax 616.391.1521
- Patient mail request to: Spectrum Health, HIM Operations Supervisor, Mailcode 063, 100 Michigan Street NE, Grand Rapids, MI 49503
- To contact HIM Supervisor call 616.643.9002

HIM STAFF USE ONLY

Date request received _____

☐ 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 _____