TAB 41
Request for Amendment of Protected Health Information

See attached

DEPAUL FAMILY AND COMMUNITY SERVICES
REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION

Patient's Name:	______________________		
	Last	First	Middle
Home Address:	______________________		
	______________________		
Home Phone:	__________		

I hereby request that DePaul Family and Community Services ("FCS") amend **[please check all boxes that apply]**:

☐ My medical records

☐ My billing records

☐ Other: ______________________

I understand that FCS may deny this request as permitted under federal law. I further understand that if FCS denies my request, I will be informed in writing by FCS of its reason for the denial and what I should do if I disagree with the denial. I further understand that FCS will notify me of its decision to accept or deny my request within 60 days of receiving this request. If FCS is unable to comply with my request within this time frame, I understand that it may extend the applicable deadline for up to an additional 30 days by notifying me in writing.

1. Describe the information you want amended (*e.g.*, services or therapist medical record notes)
____
____
____
____

2. Date(s) of information to be amended (*e.g.*, date of office visit, treatment, or other health care services) ______________________

3. What is your reason for making this request?______________________
____
____

4. How is the entry incorrect, incomplete, or outdated?______________________
____
____

5. What should the entry say to be more accurate or complete? (Please be as specific as possible) ____

____
____
____
____

6. Do you know of anyone who may have received or relied on the information in question (such as your doctor, health plan or other health care provider)?
___ yes ___ no

If yes, please specify the name(s) and address(es) of the organizations or individuals(s).

____
____
____
____

I, the undersigned patient or authorized personal representative of the patient, am requesting the amendment described above.

By: ____________________________ ____________ __, 20__
Signature of Patient (or Personal Representative) Date of Signature

INSTRUCTION: Please complete the following information if the patient's parent or other personal representative will sign this request form. The patient must be at least 12 years old to sign this request form.

____
Printed Name of Personal Representative

____
Relationship of Personal Representative to Patient
(*if applicable*)

* * * * *

After you have completed this Request for Amendment, please deliver it to the FCS Business Manager by mail to 2219 N. Kenmore Ave., Suite 300, Chicago, Illinois 60614, by fax to 773-325-7781 or by email to DePaulFCS@depaul.edu. If you have any questions regarding this Request for Amendment form, please contact the FCS Business Manager by phone at 773-325-7788 or at the addresses or phone numbers in the preceding sentence.

FOR FCS USE ONLY

Amendment has been: ___ Accepted___ Denied

If denied, check the reason for denial:

___ Protected Health Information is accurate and complete
___ Protected Health Information was not created by FCS
___ Protected Health Information is not part of the patient's Designated Record Set
___ Protected Health Information is not accessible by the patient under FCS's policy regarding the patient's right to access his or her Protected Health Information
___ Protected Health Information is MH/DD Information that is unavailable to a parent or guardian under Illinois Mental Health or Developmental Disabilities Confidentiality Act

Comments ____

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Signature of FCS Director ________________________________Date ________, 20__