Request for Amendment of Protected Health Information

This request applies to the protected health information created at:

☐ Herrin Hospital ☐ Memorial Hospital of Carbondale ☐ St. Joseph Memorial Hospital

☐ Southern Illinois Healthcare Medical Group

Patient Name First: _____ Middle: _____ Last: _____

Home Address: Street:_____

City: _____ State: _____ Zip: _____

Phone Number: _____

Date of Birth: _____

I hearby request that Southern Illinois Healthcare / Southern Illinois Healthcare Medical Group amend my (please check all boxes that apply:

☐ Medical records ☐ Billing Records

☐ Records used by Southern Illinois Healthcare / Southern Illinois Healthcare Medical Group to make decisions about me

☐ Enrollment, payment, claims adjudication, case or medical management records

I understand that Southern Illinois Healthcare/ Southern Illinois Healthcare Medical Group may deny this request as permitted under federal or Illinois law, and that I will be informed by Southern Illinois Healthcare concerning the basis for the denial along with instructions concerning my right to submit a statement of disagreement with such denial. I further understand that Southern Illinois Healthcare /Southern Illinois Healthcare Medical Group will notify me of its decision to accept or deny my request within sixty (60) days of receiving this request. If Southern Illinois Healthcare /Southern Illinois Healthcare Medical Group 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 thirty (30) days by notifying me in writing.

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1. Describe the information you would like to have amended (.e.g., nursing/physician notes, tests results).

_____

_____

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2. Identify the date(s) of the entry to be amended (e.g., date of visit, treatment or other healthcare services.)

3. What is your reason for making this request?

4. How is the entry incomplete, incorrect, or outdated?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 (e.g., your doctor, pharmacist, health plan or other healthcare provider)?
_____ YES _____ NO
   a. If YES, please specify the name(s) and address(s) of the organization(s) or individual(s)

Signature of patient or personal representative: _____

Date: _____

Return this form to:
Privacy Office
Health Information Department
Southern Illinois Healthcare
1385 E Main
Carbondale, IL 62901